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The moral world of the emotionally disturbed: an exploratory study.

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THE MORAL WORLD OF THE EMOTIONALLY DISTURBED: AN EXPLORATORY STUDY

A Thesis Presented

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I. INTRODUCTION

In the past half-century of psychological theorizing and research, there has been a growing interest in the concepts of mental illness and moral development. These areas both have man as their common element, but attempts to look at their interconnections have previously been clouded by inadequate knowledge of the separate elements themselves. Since this thesis concerns those interconnections, a clearer and more concise exposition of the moral-interpersonal world of the emotionally disturbed is perhaps called for.

Theory. To begin on a broad base, the works of Martin Buber provide an inspiring and insightful philosophy of the interpersonal nature of man. For Buber (1965), "The basis of man's life with man is twofold, and it is one--the wish of every man to be confirmed as what he is, even as what he can become, by men; and the innate capacity in man to confirm his fellow-men in this way [p. 102]." In contrasting the I-Thou world of mutuality and relation with the I-It world of experiencing and using, Buber makes vivid the life lived between man and man, the life of dialogue. In order to fulfill his twofold nature, man must create a separate self (I) with which to face the world, and yet must also enter into relation with others (Thou). It becomes each person's responsibility and claim to live toward, rather than away from, others, to be present when another makes a

demand or a call.

A tendency Buber perceived in the early forms of psychotherapy, particularly Freudian and Jungian analysis, was its almost exclusive concentration on the self, on the psychological state of the individual. Buber (1965) points out the inherent contradiction in such an approach, writing "The inmost growth of the self is not accomplished in man's relation to himself, but in the relation between the one and the other, between men...[p. 104]." In Buber's system, then, emotional problems are viewed as failures of dialogue, experiences of unnatural isolation from the world of community. Whatever the causes, "A soul is never sick alone, but there is always a between-ness also, a situation between it and another existing being." (Buber, 1967, p. 142) Therapists who have closely followed Buber's philosophy see the goal of therapy as one of helping a stronger self develop, and then turning this self towards the world of others. One such therapist, Hans Trüb (1964), describing the second phase of therapy, says he "steps over to the side of the implicated world and expects of the patient, by this time potentially healthy, that he now break out of the self-incarceration and turn towards the world with his whole soul ...[p. 499]."

Boss (1963), a disciple of Heidegger's and pioneer of Dasein-analytic therapy, also raises the sights of psychology from the personal to the interpersonal, from the psychological

to the dialogical:

> For we never exist primarily as different subjects who only secondarily enter into interpersonal relations with one another and exchange ideas about the objects all of us perceive. Instead, as any direct observation shows, we are all out there in the world together, primarily and from the beginning, with the same things shining forth in the common light of all our existences. [p. 55]

In his discussion of emotional problems, Boss claims that "no psychopathological symptom will ever be fully and adequately understood unless it is conceived of as a disturbance in the texture of the social relationships of which a given human existence fundamentally consists...all psychiatric diagnoses are basically only sociological statements [p. 56]."

One essential aspect of the interpersonal world is the area of moral judgment. Moral questions revolve around a concern for and an awareness of other's needs and rights. Morality cannot be an issue in an interpersonal vacuum, for it requires some kind of relationship to exist between men. Both Buber and Boss stress the responsibility inherent in living with others, and discuss the guilt that results from a failure to meet these responsibilities. But perhaps Mowrer (1961) is the most direct in discussing this connection between interpersonal life, morality, and mental illness. According to Mowrer "Man is preeminently a social creature and...he lives or dies, psychologically and personally, as a function of the openness, community, relatedness,

and integrity which by good action he attains and by evil action destroys [p. 44]." The central issue for Mowrer is how the individual has treated others, how he has dealt with the demands and calls of mutuality. His deceptively simple point is that "there is a connection between 'sin' and 'sickness', i.e., between how one deals with others and what happens to oneself [p. 229]."

Boisen (1936), a former psychotic patient, believes many forms of psychosis to be the result of spiritual, or religious, difficulties. The word "moral" could be used as well in this context. From his first-hand experience and observations, Boisen believes that "the primary evil...in dementia praecox...lies in the realm of social relationships, particularly in a life situation involving the sense of personal failure. We have found one characteristic common to the group as a whole; they are isolated from their fellows ...[p. 28]." Having cited this connection between spiritual conflict, interpersonal needs, and mental illness, Boisen discusses the social nature of the religious need, and concludes that "the basis of all psychotherapy is the removal of the sense of isolation [p. 210]."

Mowrer (1961), as we have seen, also believes mental illness is a "social and moral illness" (p. 91), and that therapy must proceed along socio-moral lines. A problem with his work is that his description of morality remains at this general level, and his view of therapy calls for

restitutive actions on the part of the patient. Mowrer admits to being out of his field of competence when discussing morality. For many years psychology has been attempting to deal with this emotionally laden concept, and in recent years has developed what appear to be adequate and useful methods for this purpose. Accepting as a working hypothesis that interpersonal life and the moral world are closely related, and further accepting that this moral-interpersonal area might be of considerable importance in understanding human social behavior, particularly maladaptive behavior, then we should examine closely the development of the research area of morality to see if its present knowledge throws new light on old and puzzling problems.

Research. Swainson (in Kay, 1968), a moral development researcher, makes the connection between morality and the interpersonal world using the work of Martin Buber as her justification in doing so. In accord with Buber's belief that the reality of existence is personal relations, Swainson concludes that morality emerges from relationships. As Kay (1968) describes Swainson's system, "morality emerges from the tension between self and society [p. 98]." The tension is one between "a morality of being true to oneself and the morality of relating to others [Kay, 1968, p. 98]." The need for unity with others is an early physiological survival pressure for the infant and child, and a later psychological survival pressure for the adolescent and adult.

Early, the needs for inclusion and affection become crucial, with control needs becoming more important to the matured and hopefully independent adult. To live in the world with others, and still exist as a separate human being, necessitates a dual-concern in actions and judgment: a concern for one's independence and uniqueness, coupled with an equal concern for one's connection with others and common humanity. Moral development is a statement of a person's progress in resolving this tension in his life, his success in living with a world-view which recognizes a differentiated self, but does not overlook the fact that existence is a social enterprise.

In his early moral judgment research, Sharp's (1898) major contention was that "there exist different types of moral judgment, which are represented with varying degrees of completeness in different persons [p. 198]." This early statement appears more insightful as Piaget's and Kohlberg's work in this area is described below. Sharp's method of measuring moral judgment was to provide his subjects with ten hypothetical situations involving moral decisions, and have them resolve the situations according to their own beliefs. This method is used in exactly the same fashion today, some seventy years later, by Lawrence Kohlberg. Sharp's "objective attitude" enabled him to refrain from labeling some answers "more moral" than others, an emotional moderation that many future morality researchers were unable to

attain (see Pittel and Mendelsohn's (1966) critique of moral value measurement).

With Piaget's writings (in Kay, 1968), the stage is set for the sequential level development of moral judgment carried on later by Kohlberg. According to Piaget, from a morality based on restraint and rigid law, the child moves to a morality of social experience, cooperation based upon the intellectual faculty of reciprocal thinking, and finally to a point of moral equity, a stage of autonomy of judgment. Piaget's complete four stages of moral development are, 1) egocentric, 2) authoritarian, 3) reciprocity, and 4) equity. Intellect, the capacity for reciprocal thinking, for putting oneself in another's place, bridges stages two and three, while a growing humanity or altruism takes the child to the final stage of equity. Piaget offers reasons for changes in moral judgment, one being the intellectual growth due to maturation, the other two stressing interpersonal aspects: increased dealings with peers as opposed to adults, and a decrease in adult strictures and domination.

Lawrence Kohlberg (1968), who describes himself as "inspired by Jean Piaget's pioneering effort to apply a structural approach to moral development [p. 25]," has developed a schema for the development of moral thought. It consists of three basic levels with two related stages within each level. "These levels and stages may be considered separate moral philosophies, distinct views of the socio-

moral world [p. 25]." A person is placed in one of Kohlberg's stage-level combinations on the basis of his elaborative responses to four moral conflict stories, the method being markedly similar to Sharp's design. Both Sharp's and Kohlberg's methods (i.e., having the subjects resolve moral dilemmas) conform to Pittel and Mendelsohn's (1966) recommendations for the measurement of moral values. The subjects' attitudes are viewed as subjective phenomena, and are not evaluated with respect to societal norms or preordained visions of "moral" and "immoral." Sharp and Kohlberg evaluate each individual's personal response to a moral situation not in terms of normative or conventional values, but simply as an expression of his own world-experience. The subject does not merely answer questions as to right or wrong, to which the tester has the correct moral choices. He describes his own view of a morally conflictual situation.

Returning to the details of Kohlberg's theory, in the preconventional or premoral level, the environment is more important to the child than are actual human beings. This is a very physical stage of development, with moral values residing in external, physical events or in physical needs, rather than in persons or standards. The "obedience and punishment" orientation, a deference to the force rather than the person of authority, characterizes the first stage of this premoral level (Stage 1). The second stage has been called "narcissistic," egocentric," or the stage of instru-

mental relativists" (Stage 2). Good behavior satisfies one's own needs, and the only sense of reciprocity that exists is again a physical, ego-centered one. Exchange exists, but as Kohlberg says, "human relations are viewed in terms like those of the marketplace [p. 26]." The orientation to reciprocity is a very naive one, devoid of the principles of justice or gratitude--"You scratch my back and I'll scratch yours" (p.26).

The conventional level of morality centers on performing a "good" or "right" role, being the "good boy or girl." Order, and the expectations of others, must be maintained. The third stage of development is referred to as the personal concordance stage (Stage 3). Here, the person performs actions which will please or help others, tries to fulfill a "natural" role in society, and be seen as a "nice guy." The maintenance of good relations is all-important. The next stage within this conventional level emphasizes an orientation to authority, and can be called the "law and order" stage (Stage 4). The social order is supreme, and its rules are fixed and binding. One does "one's duty," and shows respect for authority. In every society studied by Kohlberg, Stage 4 is the most frequent mode of moral judgment in adults.

Concluding Kohlberg's system, the third and highest level is the postconventional or "principled" one, in which "Moral value resides in conformity by the self to shared or shareable standards, rights, or duties [Kohlberg, 1969, p.

376]." Both stages in this level emphasize a mutuality in life, concern for others' rights from a nonegotistic perspective. There is a genuine and flexible concern for the social relations of life. The first stage is the social contract orientation (Stage 5). Right action is based upon consensus, or "standards which have been critically examined and agreed upon by the whole society [Kohlberg, 1968, p. 26]." Majority rule is the value, with laws or rules subject to change if the society so wills it. As Kohlberg points out, this stage sums up the spirit of our American Constitution.

The highest stage in Kohlberg's scale is one of individual principles (Stage 6). Abstract, ethical principles originate which are universal and comprehensive, and these supercede formal rules or laws. Mutual respect and justice are emphasized, and the individual conscience is free and creative. The personal principles Kohlberg (1968) lists are "justice, reciprocity and equality of human rights, and respect for the dignity of human beings as individual persons [p. 26]." The person runs a greater risk of violating group norms or laws at this stage than at any other, even greater than the risks of the premorally guided individual. Kohlberg (1968) has found that his stages of moral development are relevant in foreign cultures (Great Britain, Canada, Taiwan, Mexico, and Turkey), since all of these societies have some basic institutions--family, economy, law, government--that permit role-taking opportunities.

The similarities between Piaget and Kohlberg are evident. Kohlberg's preconventional has the flavor of Piaget's egocentric, Kohlberg's conventional, the spirit of Piaget's authoritarian, and Kohlberg's principled stages have their parallels in the Piagetian stages of reciprocity and equity. Another cognitive-developmental researcher, Loevinger (1966), lists six stages of ego development that closely parallel Kohlberg's moral hierarchy. Corresponding to Kohlberg's Stages 1 through 6 are Loevinger's Impulse-ridden, Opportunistic, Conformist, Conscientious, Autonomous, and Integrated stages.

Having briefly summarized the sequence of stages in Piaget's, Kohlberg's, and Loevinger's systems, it would be helpful at this point to present some of the basic assumptions underlying the theories of these cognitive-developmental psychologists. Kohlberg states (1969) that

> The cognitive-developmental assumption is that basic mental structure is the result of an interaction between certain organismic structuring tendencies and the structure of the outside world, rather than reflecting either one directly. This interaction leads to cognitive stages which represent the transformations of simple early cognitive structures as these are applied to (or assimilate) the external world, and as they are accommodated to or restructured by the external world in the course of being applied to it. [p. 352]

These cognitive stages have four major characteristics (Kohlberg, 1969):

1) Stages indicate distinct or qualitative differences in modes of thinking.

2) These different modes of thinking form an invariant stepwise sequence in individual development. The speed of development may vary, but the sequence is immutable.

3) Each of these different and sequential modes of thought forms a "structured whole." Responses are not tied to a particular situation or task, but are evidence of an underlying thought organization.

4) Cognitive stages are hierarchical integrations, i.e., each stage is a differentiation and integration of a set of functional contents present at the prior stage. The levels are abstract concepts, not age-specific stages, and in the hierarchical model there is one characteristic, or predominant, stage for each person. In the Kohlberg system, it is thus common for mixed-type scores to occur. Here, two stages of moral cognition are heavily employed in one subject's responses--one of major importance and frequency, the other representing a minor, but significant, percentage of use. These mixed scores can represent transitional points from stage to stage (e.g., 3(4)), or can be examples or separate and distinct moral philosophies (e.g., 4(2)). In all cases, the score not in the parentheses is the major stage of moral judgment.

Dealing with another aspect of the developmental theory, Kohlberg (1969a) discusses two types of regression to lower stage usage that may occur. These are functional and structural regressions. The functional regression (found by

Haan, Smith, & Block (1968) to exist in some college activists) is the choice of modal usage of a premoral stage of judgment with the retention of the earlier capacity to use conventional and even postconventional thinking. In a structural regression there is a lack of awareness of alternative of higher moral points of view, and this type of regression has been found to exist in some schizophrenics, criminals, and people over sixty-five (Kohlberg, 1969a). Additionally, in discussing moral development, there is also the possibility that a person may have failed to develop beyond a premoral stage, and so the concept of regression need not always be employed.

The major characteristics of cognitive stages are the theoretical basis of Kohlberg's six stages of moral judgment, and they can be demonstrated by taking another look at the stages in terms of the differing conceptions of reciprocity in each stage (Kohlberg, 1969). From Stage 1's reciprocity of obedience and freedom from punishment, comes Stage 2's literal exchange philosophy, followed by Stage 3's gratitude orientation and reciprocal maintenance of expectations, Stage 4's work and conformity view of keeping one's word and bargain, Stage 5's social contract between free and equal individuals, and, finally, Stage 6's universal ethical principles of reciprocal role-taking. The large distinction between conventional and principled morality is significant. Where the conventional moral thinker feels the social order

embodies the structures of reciprocity, the principled thinker believes the social order itself is derived from the principles of justice and principles of universalized reciprocity (Kohlberg, 1969, pp. 398-399).

What Kohlberg means by morality is the way the individual structures his relations with others, the way he lives and acts in society. Kohlberg's conceptualizations are a natural progression from the work of Buber and the interpersonal theorists previously mentioned, only in Kohlberg's they are tied to an empirical measure of cognitive development. Kohlberg (1969) sounds strikingly similar to Buber when he claims that

> The direction of social or ego development is also toward an equilibrium or reciprocity between the self's actions and those of others toward the self...social cognition always involves role-taking, i.e., awareness that the other is in some way like the self, and that the other knows or is responsive to the self in a system of complementary expectations. [p. 349]

Buber uses terms such as "inclusion" or "making-present" to describe putting yourself in another's situation and experiencing an encounter from his pole of the relationship. In a more literary fashion, Buber supports Kohlberg's view with this description of role-taking:

> This "making-present" increases until it is a paradox in the soul when I and the other are embraced by a common living situation, and the pain which I inflict upon him surges up in myself, revealing the abyss of the contradictoriness of life between man and man. [Buber, 1965, p. 103]

The stages or moral development actually represent the successive shapes which the perfecting, refining, and tuning

of this capacity for reciprocity take. To be able to experience honestly an interaction from the other person's perspective requires, at least, conventional moral judgment, and this ability is absent in the premoral stages. Being separate and alone in a world of others, being at once an individual and a social creature, places certain demands on the human being. Kohlberg (1969) calls this "the area of the conflicting claims of selves...the area of morality, or of moral conflict [p. 398]."

Overview of the study. The interpersonal world of the emotionally disturbed has been described as limited and isolated, their patterns of relating have been viewed as ineffectual, confused, or narcessistic, and their guilt over personal experiences and failures has seemed self-destructive in the light of their incapacity to change their way of life. In more psychological language, they may be experiencing few role-taking opportunities, leading lives which become more and more private as the years slip by. And what is more, they may be unable to make use of any new opportunities for relation which may arise, since their way of viewing the world may have ruled out certain types of experiences in their lives. All of these descriptions and hypotheses are congruent with the picture of the premoral individual's world given in the Kohlberg Scale of Moral Development. The actual exploration of the socio-moral world of the emotionally disturbed is the basis for the following study. By administering

the Kohlberg Interview to matched groups of mental patients and of control medical patients, it was hoped to detect differential trends in moral judgment between the two populations.

Within the mentally disturbed group, the social alienation and withdrawal of the schizophrenic, and the tense, anxiety-dominated interpersonal world of the neurotic, would lead one to predict a more primitive, or more premoral, orientation in these groups than in a group of "normal" subjects. Morality develops as relational capacity develops, and sophisticated moral judgment cannot exist in an interpersonal void. The descriptions of the existential death of the schizophrenic points to both an interpersonal and a moral failure. If others are not perceived as real, how can their interests figure heavily in the moral judgments of the schizophrenic? Indeed, it could be hypothesized that proceeding from the schizophrenic, to the neurotic, to the psychologically "normal" medical control patient, the socio-moral world defined by Kohlberg's stages should increase from the premoral to the conventional level. Moral judgment, intuitively, should show the same relationship to these groups as does the quality of interpersonal life, increasing in effectiveness, mutuality, and sophistication as one proceeds from the disturbed to the more or less "normal" or adjusted. The importance of this moral-interpersonal realm has been discussed above. The knowledge of a person's cognitive stage of moral development

can have implications for the overall understanding of pathological states, and it may serve as a foundation for effective psychotherapy.

This study is exploratory in nature, and can be viewed as an initial attempt to apply the Kohlberg Moral Judgment system to personality disorders. It is hoped that the relevance of moral-interpersonal issues in understanding psychological disturbance may be established through the use of the Kohlberg system.

II. METHODOLOGY

Subjects. Sixty male veterans from the Kingsbridge Veterans Administration Hospital, Bronx, New York, agreed to participate in the study. The experimental group consisted of thirty patients from the three psychiatric wards of the hospital, and the control group consisted of thirty patients from the medical wards of the same hospital. No medical patient employed in the study had previously spent time on a psychiatric ward. Medical patients were employed as control Ss because they shared the general experience of being hospitalized in a VA facility, and they came from similar socio-economic groups. The educational level and socio-economic status of both the experimental and control groups were evaluated on the basis of the patient's statement of education and occupation. The two groups were found to be largely equivalent on these factors.

The criterion for the selection of the mental patient group was simply hospitalization for emotional problems. This group turned out, based on their most recent official diagnosis, to consist of twenty schizophrenic and ten neurotic patients. This diagnosis was determined at the patient's psychiatric interview following his admission to the hospital. The varying types of schizophrenia and neurosis noted in these thirty diagnoses seemed sufficiently vague and unsubstantiated to warrant looking at the three groups

in the study (medical controls, neurotics, and schizophrenics) simply as roughly hewn points along a continuum of increasing emotional disturbance. More detailed or elaborate explanations of results with regard to particular etiologies of various forms of schizophrenia and neurosis are beyond the scope of this study (and the present state of classification of maladaptive behavior). The two major groups (mental and medical) or thirty Ss each were matched, insofar as possible, on age, religion, educational level, socio-economic status, and number of hospitalizations.

Measures. The measure employed was Kohlberg's Moral Judgment Interview, which contains four hypothetical moral conflict stories and corresponding sets of probing questions (see Appendix A). The method of scoring used was Kohlberg's global rating system, where moral issues are scored within each story, leading to a global moral stage score for each story, and where, finally, the global stage scores of the four stories are combined into one "global-global" stage score for the individual S.

A subject might, for example, give Stage 3 responses for most issues in a particular story (some typical moral issues are Life, Role Relationships, Punishment, and Authority), leading to a Stage 3 global score for the story. In combining global scores from the four stories into one global-global score, an overall modal stage is assigned if 50% or more of the stories are at that stage. In deciding

on this percentage, a mixed score (e.g., 4(5)) is weighted 1 for the minor code, which is in parentheses, and 2 for the major code, which is out of parentheses. A pure score (e.g., 5) is weighted 3. A minor global-global stage is assigned if 25% or more of the weighted stories are at that stage. A pure-type global-global score requires 75% or more of the weighted stories to be at that stage.

As a concrete example, a subject might receive a global score of 3 on Story I, a global score of 3(4) on Story III, a global score of 4 on Story IV, and a global score of 3 on Story VIII. Using the weighted scores, the following chart can be constructed:

	Moral Stages				
	1	2	3	4	5	6
Story I			3			
Story III			2	1		
Story IV				3		
Story VIII			3			
			8 (67%)	4 (33%)		

This yields a global-global score of 3(4), Stage 3 being the modal stage of usage (above 50%), and Stage 4 being the minor stage (above 25% of the stories are at this stage).

The experimenter scored all protocols without knowledge of the subject's identity of group affiliation. The scoring procedure was learned by the experimenter at a three-day

workshop conducted by Dr. Kohlberg and his associates at Harvard University in June of 1970.

Procedure. The Kohlberg Moral Judgment Interview was administered individually for all Ss in one session, usually lasting one hour. Subjects were told that the study concerned finding out how patients in the hospital felt about certain issues. Each S was then told,

> I will read some stories to you, and after each story I shall ask you some questions about the story. There are no right or wrong answers to these questions, different people have different opinions. I just want you to give your own ideas and opinions. This is not a test, and no one in the hospital will see any of your answers.

Some mental patients and some medical patients were unable to or had no desire to respond to the Kohlberg stories, and so the final sixty Ss are most likely a naturally selected group of the more cooperative (or passive), more interpersonally comfortable patients initially approached on a random basis. Interviews of medical and mental patients were randomly distributed over the five weeks in which Ss were run, so that no one group was seen at a particular point in time. One difference in administering the interview to the two groups was that the majority of mental patients were able to come to an office to be interviewed, whereas the majority of medical patients were confined to their beds and had to be interviewed on the ward.

III. RESULTS

Each S in this study received a Global-Global Moral Judgment Score (see Methodology section) which consisted of either a single modal stage of usage (e.g., 3) or a mixed-type stage score (e.g., 3(2)). The weights assigned to the components of the mixed score, according to Kohlberg's scoring procedure, are two-thirds for the major stage of usage (the stage not in parentheses), and one-third for the minor stage (the stage in parentheses). The original Kohlberg stage scores for the sixty Ss can be found in Table 1. For statistical purposes, a single numerical score was desired, and so a simple transformation of the Global-Global ratings was performed, Using the weights described above, each single stage score was multiplied by three (e.g., a Stage 3 score = 3 x 3 = 9). The components of the mixed-type scores were multiplied by their respective weights (e.g., a mixed-type score of 3(2) = 2x3 plus 1x2 = 8). The scores possible in this transformed system range from 3 (a Kohlberg score of Stage 1) to 18 (a Kohlberg Stage 6).

Completely randomized one- and two-factor analyses of variance were used throughout the data analysis, allowing for simple and complex comparisons of moral judgment involving patient group, marital status, religion, age, and number of hospitalizations. Because of the disproportionate frequencies of the variables that are found in these patient populations, the method of expected cell frequencies was

TABLE 1

Global-Global Moral Judgment Stage Scores
for Mental and Medical Patients

Mental Patient Group		Medical Patient Group	
Subject No.	Score	Subject No.	Score
1	4(3)	1	3(4)
2	3(2)	2	3
3	2(1)	3	4
4	3	4	3
5	2	5	2(3)
6	3	6	3
7	3(4)	7	4
8	3	8	3(5)
9	3(4)	9	3
10	2(4)	10	3
11	3	11	2(3)
12	2(3)	12	4
13	3(5)	13	3
14	3	14	3
15	2	15	3
16	3	16	4
17	3(2)	17	3(5)
18	4(3)	18	4(3)
19	3(2)	19	4(3)
20	4	20	4
21	4(3)	21	4(3)
22	3	22	3
23	3(2)	23	3(4)
24	4	24	3
25	2	25	4(5)
26	3(2)	26	4
27	3(2)	27	3
28	4(2)	28	5(4)
29	4(3)	29	4(3)
30	4(3)	30	4(3)

employed for the analyses (Myers, 1969, p. 109).

The first overall analysis compared the two major patient groups in the study, the mental patient and medical patient groups, to see if the hypothesized difference in moral development would be borne out. The mean "moral development" score (all scores discussed in this section will be the transformed scores described above, ranging from 3 to 18) for the thirty mental patients was 8.96, while the mean score for the thirty medical patients was 10.30. The results of this analysis are presented in Table 2. The difference between mental and medical patients' moral judgment scores was significant ($p < .01$), medical control patients, as a group, evidencing a clearly higher level of moral stage usage than did the mental patient group.

Dividing the mental patient group into its two subgroups, schizophrenics and neurotics, and comparing the moral judgments now of the three groups in the study, the results showed the twenty schizophrenic patients to have a mean score of 8.85, the ten neurotic patients a mean score of 9.20, and, as cited before, the thirty medical patients' mean score was 10.30. The analysis of the data, seen in Table 3, indicates that there is a significant difference ($p < .05$) between schizophrenic, neurotic, and medical patients' levels of moral judgment. A Newman-Keuls analysis was employed to examine the nature of the differences between schizophrenic, neurotic, and medical control patient mean moral judgment scores which

TABLE 2

Analysis of Variance Comparison of Moral Judgment Scores for Mental and Medical Patients

Source of Variance	df	MS	F
Patient Group (A)	1	26.7	8.53*
S/A	58	3.13	

*$p < .01$.

TABLE 3

Analysis of Variance Comparison of Moral Judgment Scores for Schizophrenic, Neurotic, and Medical Patients

Source of Variance	df	MS	F
Patient Group (A)	2	13.77	4.34*
S/A	57	3.17	

*$p < .05$.

led to the significant overall F. The results of the Newman-Keuls analysis (Table 4) indicate that the significant difference in the overall analysis of variance was accounted for by the difference ($.05 < p < .075$) between schizophrenic patient and medical control patient mean moral judgment scores. The fact that the analysis of variance comparing schizophrenic, neurotic, and medical patients' moral judgment scores was significant at the .05 level, while the only significant difference in the Newman-Keuls method was slightly above that level may be explained by noting that the Newman-Keuls is a less powerful test than is the analysis of variance.

Along with the main effect of patient group, other personality variables might be interacting with moral judgment. Marital status is one such variable. Due to the naturally occurring frequencies of this variable in these patient groups, it was not matched across patient populations. Contrasting first the combined effects of marital status (single as opposed to married, separated, or divorced), and patient group (mental or medical), Table 5 provides the basic information of sample size and group moral judgment score means. There is an increase of approximately one point across both variables, either proceeding from single to married individuals within a patient group, or proceeding from mental to medical patient status at either level of the marriage variable. The mental patient group's moral judgment scores were lower than the medical patient group's by approximately one point in

TABLE 4

Newman-Keuls Analysis of Difference in Moral Judgment Scores for Schizophrenic, Neurotic, and Medical Patients

		Schizophrenic 8.85	Neurotic 9.20	Medical 10.30
Schizophrenic	8.85	----	.35	1.45*
Neurotic	9.20		----	1.10
Medical	10.30			----

*.05 < p < .075.

Schizophrenic Neurotic Medical

Note.--Treatments underlined by a common line do not differ from each other; treatments not underlined by a common line do differ.

TABLE 5

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Single Mental Patients, Married Mental Patients, Single Medical Patients, and Married Medical Patients

	Mental	Medical
Single	$\bar{X}$ = 8.46 (N = 15)	$\bar{X}$ = 9.5 (N = 8)
Married	$\bar{X}$ = 9.46 (N = 15)	$\bar{X}$ = 10.59 (N = 22)

both marital conditions. Indeed, a single medical patient's score was slightly higher than a married mental patient's. The analysis of these results, Table 6, indicates that the main effect of the difference between mental and medical patients was again significant ($p < .05$), and also shows that the main effect of the difference between single and married patients was significant ($p < .05$) as well, married individuals showing a higher stage of moral development. No interaction effect was apparent. If instead of two patient groups (mental and medical), this population is divided into three groups (schizophrenic, neurotic, and medical--see sample sizes and group means in Table 7), and the same two-factor analysis of variance is run, the results, as shown in Table 8, evidence the same significant difference ($p < .05$) between single and married patients across the three groups. The main effect for the differences between the three patient groups was reduced to slightly above the .05 level as a result of this breakdown of the patient group variable from two to three groups. Again, there was no significant interaction effect present.

In a study of moral judgment the variable of religion is certainly of interest, and it was explored in this research. Ss stated their own religious affiliation, with four Ss expressing no affiliation and therefore being eliminated from this analysis. It was impossible to divide the patient groups into two subgroups because of the extremely small sample size

TABLE 6

Analysis of Variance Comparison of Moral Judgment Scores for Single and Married Mental and Medical Patients

Source of Variance	df	MS	F
Patient Group (A)	1	18.1	6.09*
Marital Status (B)	1	14.2	4.78*
AB	1	3.3	1.11
S/AB	56	2.97	

*$p < .05$.

TABLE 7

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Single and Married Schizophrenic, Neurotic, and Medical Patients

	Schizophrenic	Neurotic	Medical
Single	$\bar{X}$ = 8.20 (N = 10)	$\bar{X}$ = 9 (N = 5)	$\bar{X}$ = 9.5 (N = 8)
Married	$\bar{X}$ = 9.5 (N = 10)	$\bar{X}$ = 9.4 (N = 5)	$\bar{X}$ = 10.59 (N = 22)

TABLE 8

Analysis of Variance Comparison of Moral Judgment Scores for Single and Married Schizophrenic, Neurotic, and Medical Patients

Source of Variance	df	MS	F
Patient Group (A)	2	9.1	2.99
Marital Status (B)	1	15.5	5.09*
AB	2	.66	.22
S/AB	54	3.04	

*$p < .05$.

of some of the resulting cells in this analysis. Mean scores and sample sizes for combinations of patient group and religious affiliation (Catholic, Protestant, and Jewish) are found in Table 9. The analysis of these data, seen in Table 10, shows a significant main effect differentiating the two patient groups once again ($p < .05$), shows no significant main effect differentiating the various religious affiliations, but does show a significant interaction between patient group and religious affiliation ($p < .01$). A graph of this interaction, along with a Newman-Keuls analysis to discover the sources of significance in the interaction effect, are shown in Figure 1 and Table 11, respectively. The significant difference in the overall interaction effect lies in the difference between Jewish mental and Jewish medical patients ($p < .05$). Of the six cells in this analysis, the mean score of Jewish mental patients is the lowest (8.38), while the mean score of Jewish medical patients is the highest (11.20). This single difference among cells accounted for the significant interaction effect found in this analysis. The sample sizes of these two groups (Jewish mental patients = 8, Jewish medical patients = 5) were quite small, however, so that this difference, while statistically reliable, is not a clearly established one.

Another variable of interest in discussing the development of moral judgment is the age of the Ss. Table 12 presents the sample sizes and mean moral judgment scores for

TABLE 9

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Catholic, Protestant, and Jewish Mental and Medical Patients

	Mental	Medical
Catholic	$\bar{X}$ = 8.72 (N = 14)	$\bar{X}$ = 10.41 (N = 17)
Protestant	$\bar{X}$ = 10.17 (N = 6)	$\bar{X}$ = 9.50 (N = 6)
Jewish	$\bar{X}$ = 8.38 (N = 8)	$\bar{X}$ = 11.20 (N = 5)

TABLE 10

Analysis of Variance Comparison of Moral Judgment Scores for Catholic, Protestant, and Jewish Mental and Medical Patients

Source of Variance	df	MS	F
Patient Group (A)	1	20.9	6.61*
Religion (B)	2	.6	.2
AB	2	17.3	5.47**
S/AB	50	3.16	

*$p < .05$.

**$p < .01$.

FIGURE 1: MEAN MORAL JUDGMENT SCORES AS A FUNCTION OF RELIGIOUS AFFILIATION FOR BOTH PATIENT GROUPS (MENTAL + MEDICAL).

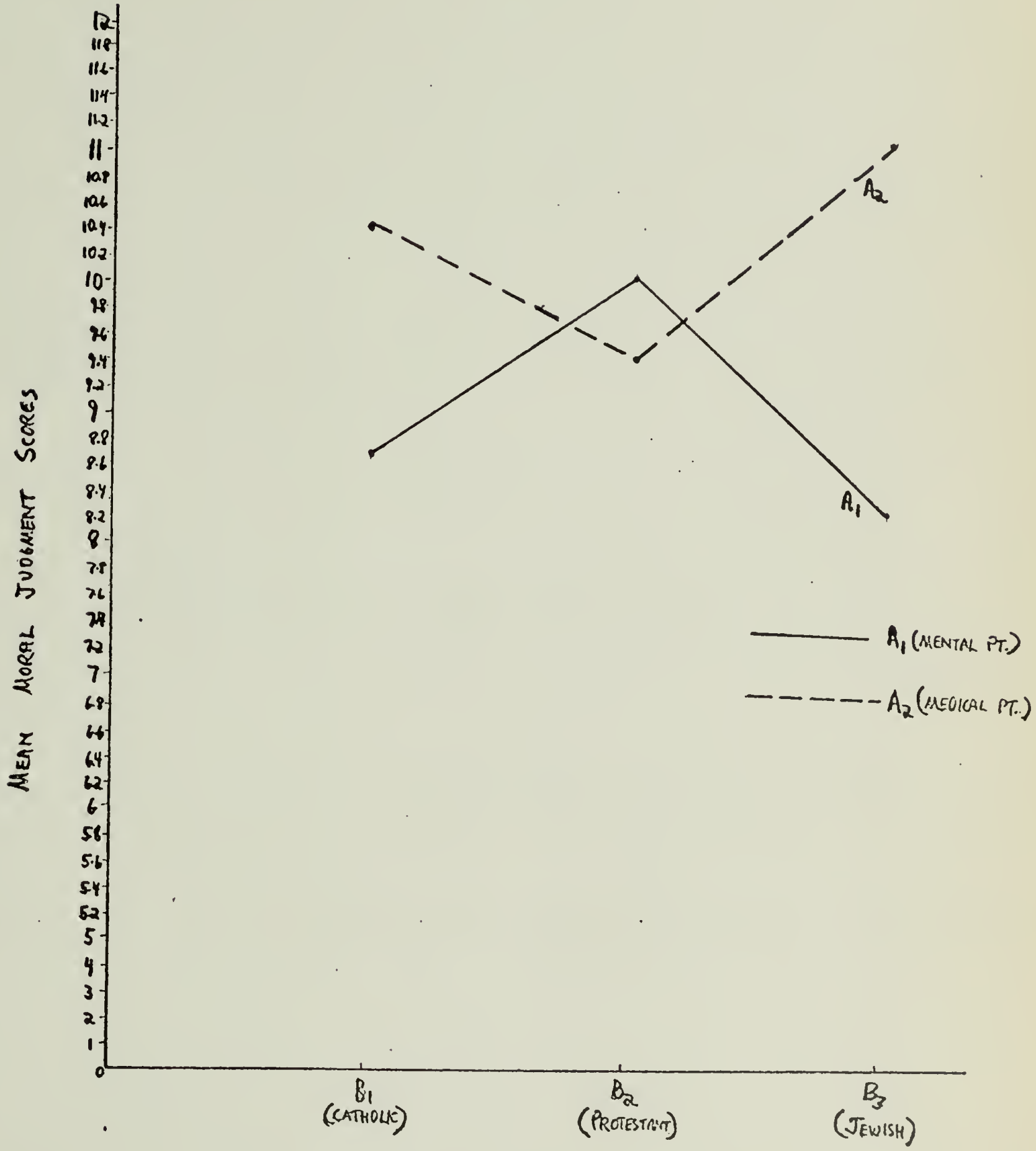


TABLE 11

Newman-Keuls Analysis of Interaction Between Patient Group and Religious Affiliation

	Jewish Mental 8.38	Catholic Mental 8.72	Protestant Medical 9.50	Protestant Mental 10.17	Catholic Medical 10.41	Jewish Medical 11.00
Jewish Mental 8.38	----	.34	1.12	1.79	2.03	2.82*
Catholic Mental 8.72		----	.78	1.45	1.69	2.48
Protestant Medical 9.50			----	.67	.91	1.70
Protestant Mental 10.17				----	.24	1.03
Catholic Medical 10.41					----	.79
Jewish Medical 11.00						----

J. Ment. C. Ment. P. Med. P. Ment. C. Med. J. Med.

*$p < .05$.

Note.--Treatments underlined do not differ from each other.

TABLE 12

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Mental and Medical Patients Under Forty and Over Forty Years of Age

	Mental	Medical
Under Forty	$\bar{X}$ = 9.0 (N = 16)	$\bar{X}$ = 10 (N = 12)
Over Forty	$\bar{X}$ = 8.93 (N = 14)	$\bar{X}$ = 10.5 (N = 18)

mental and medical patients under and over forty years of age. The analysis of the data on age in Table 13 shows the expected significant ($p < .01$) main effect for patient group (medical patients having higher moral judgment scores than mental patients), but shows no significant main effect for age, and no significant interaction effect between age and patient group. Because sample size permitted it, in this case the patient group variable was divided into three groups (schizophrenic, neurotic, and medical patients), and Table 14 presents the sample sizes and mean scores for these groups' combinations with the two levels of the age variable. The analysis of the data appears in Table 15, and even with this additional patient group breakdown, the main effect for the differences between moral judgments of patient groups was again significant ($p < .05$), but age as a variable and the interaction of age and patient group were not significant.

One final variable of considerable importance in any hospital-based study is the number of hospitalizations experienced by each S. While the Kingsbridge VA Hospital is a relatively short-term hospital, a division of patients into those having under four and those having four or more hospitalizations was possible. The sample sizes and mean scores for mental and medical patients in these groups are given in Table 16. A further division of the patients into schizophrenic, neurotic, and medical groups was not possible with the variable of number of hospitalizations due to the fact

TABLE 13

Analysis of Variance Comparison of Moral Judgment Scores for Mental and Medical Patients Under and Over Forty Years of Age

Source of Variance	df	MS	F
Patient Group (A)	1	25.51	7.97*
Age (B)	1	.07	.02
AB	1	2.14	.67
S/AB	56	3.20	

*$p < .01$.

TABLE 14

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Schizophrenic, Neurotic, and Medical Patients Under Forty and Over Forty Years of Age

	Schizophrenic	Neurotic	Medical
Under Forty	$\bar{X}$ = 8.85 (N = 13)	$\bar{X}$ = 9.67 (N = 3)	$\bar{X}$ = 10 (N = 12)
Over Forty	$\bar{X}$ = 8.86 (N = 7)	$\bar{X}$ = 9.0 (N = 7)	$\bar{X}$ = 10.5 (N = 18)

TABLE 15

Analysis of Variance Comparison of Moral Judgment Scores for Schizophrenic, Neurotic, and Medical Patients Under and Over Forty Years of Age

Source of Variance	df	MS	F
Patient Group (A)	2	12.58	3.82*
Age (B)	1	.29	.09
AB	2	1.35	.41
S/AB	54	3.29	

*$p < .05$.

TABLE 16

Group Moral Judgment Score Means and Sample Size (in Parentheses) for Mental and Medical Patients with Under Four and Four or More Hospitalizations

	Mental	Medical
Under Four	$\bar{X}$ = 9.16 (N = 25)	$\bar{X}$ = 10.32 (N = 25)
Four or More	$\bar{X}$ = 8.0 (N = 5)	$\bar{X}$ = 10.2 (N = 5)

that no neurotic patient had more than three hospitalizations. Only ten patients out of the entire sample of sixty Ss had four or more hospitalizations, and all five of the mental patients with four or more hospitalizations were schizophrenics. An analysis of the data on the number of hospitalizations (Table 17),indicates a significant ($p < .01$) main effect for patient group, but shows no significant main effect for number of hospitalizations, and no significant interaction between patient group and number of hospitalizations.

The appearance in several of the analyses of variance of F ratios less than unity raises the possibility that the model underlying the analysis has been violated in some manner. Since one experimenter interviewed all Ss, some subtle systematic interaction effect might have been present, or perhaps some unknown source of variability entered into the analysis. Definitive answers to these suppositions are not available, but the frequency and size of the "under-one" F ratios are not so striking as to challenge the use of this method with the present data.

A story-by-story inspection of percentage of stage usage (in this case, the original Kohlberg Stages 1-6) by schizophrenic, neurotic, and medical patients (see Figures 2-5) shows differences between the groups as well as differences between general responses to the four individual stories. The schizophrenic group used a higher average percent-

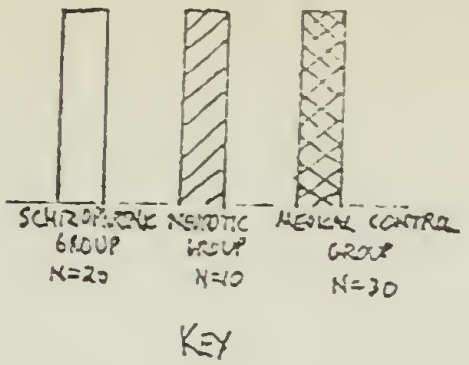
TABLE 17

Analysis of Variance Comparison of Moral Judgment Scores for Mental and Medical Patients with Under Four and Four or More Hospitalizations

Source of Variance	df	MS	F
Patient Group (A)	1	26.66	8.49*
Number of Hospitalizations (B)	1	3.41	1.09
AB	1	2.26	.72
S/AB	56	3.14	

*$p < .01$.

FIGURE 2: SCHIZOPHRENIC, NEUROTIC, AND MEDICAL CONTROL GROUPS' PERCENT USAGE OF MORAL STAGES IN SITUATION I.



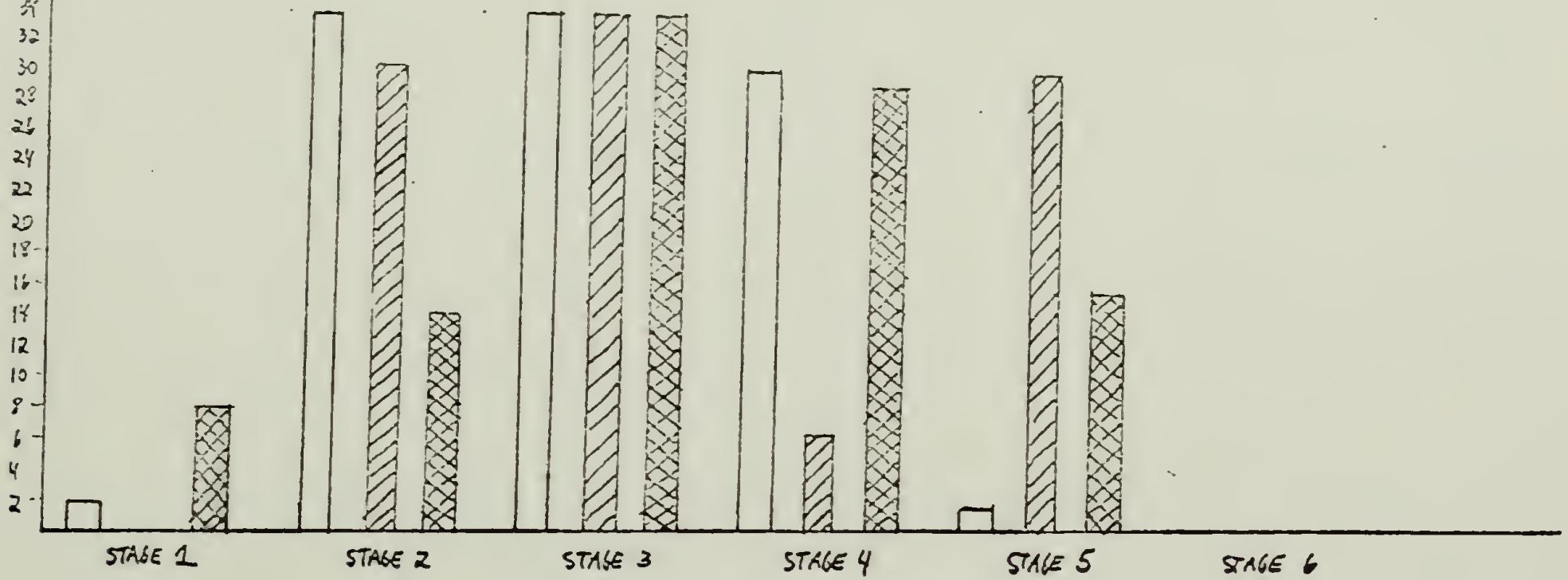


FIGURE 3 : SCHIZOPHRENIC, NEUROTIC, AND MEDICAL CONTROL GROUPS' PERCENT USAGE OF MORAL STAGES IN SITUATION III.

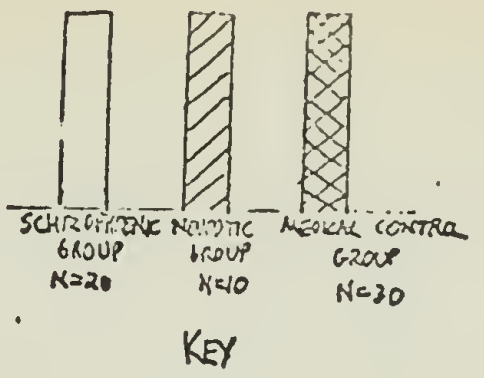


FIGURE 1 : SCHIZOPHRENIC, NEUROTIC, AND MEDICAL CONTROL GROUPS' PERCENT USAGE OF MORAL STAGES IN SITUATION III

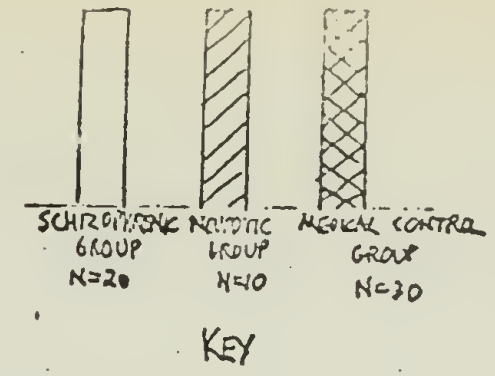
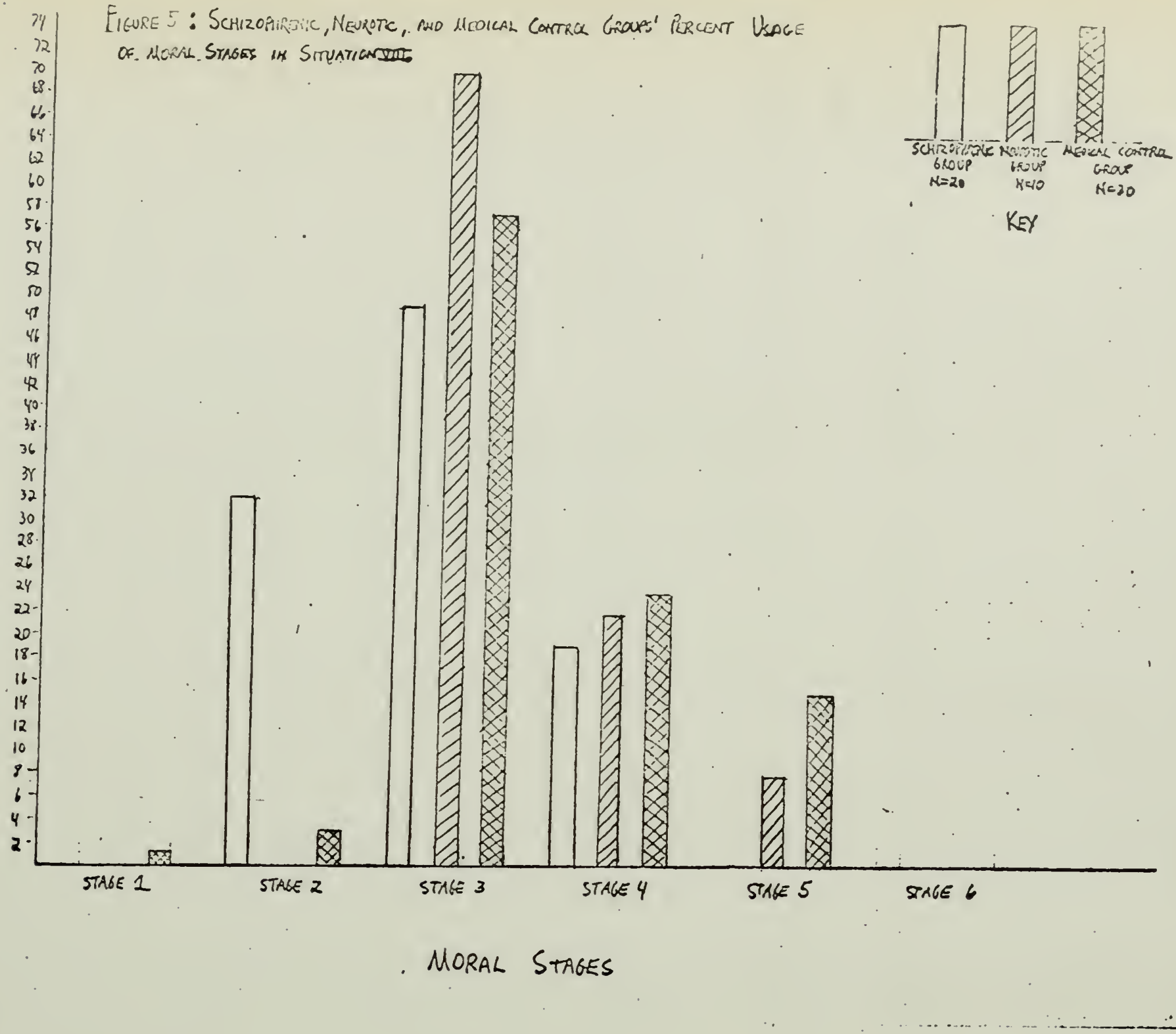


FIGURE 5 : SCHIZOPHRENIC, NEUROTIC, AND MEDICAL CONTROL GROUPS' PERCENT USAGE OF MORAL STAGES IN SITUATION VIII.



age of Stage 2 responses over the four stories (27%) than did either the neurotic (15%) or the medical (8%) groups. Additionally, schizophrenic patients employed more Stage 4 thinking (again, an average of the usage in the four stories), 30%, than did the neurotic group (20%). The medical patient group, however, showed the highest average percentage of Stage 4 thinking (24%) of all three patient groups. The neurotic patient group, on the other hand, was the highest average percentage user of Stage 3 thinking (53%), followed by the medical patients (45%), and the schizophrenic group (40%). Stage 5 thinking was not heavily used, accounting for 10% of normal subject usage, 11% of neurotic patient usage, and only 1% of schizophrenic usage. Looking at combined group responses to the four stories, for Situations I, III, and VIII, Stage 3 is clearly the most frequently used form of moral judgment. The exception is Situation IV, which drew a predominately (44%) Stage 4 response from the fifty-nine Ss who were given this story. (See Figures 6-9.)

FIGURE 6: COMBINED GROUPS (N=60) PERCENT USAGE OF MORAL STAGES IN SITUATION I.

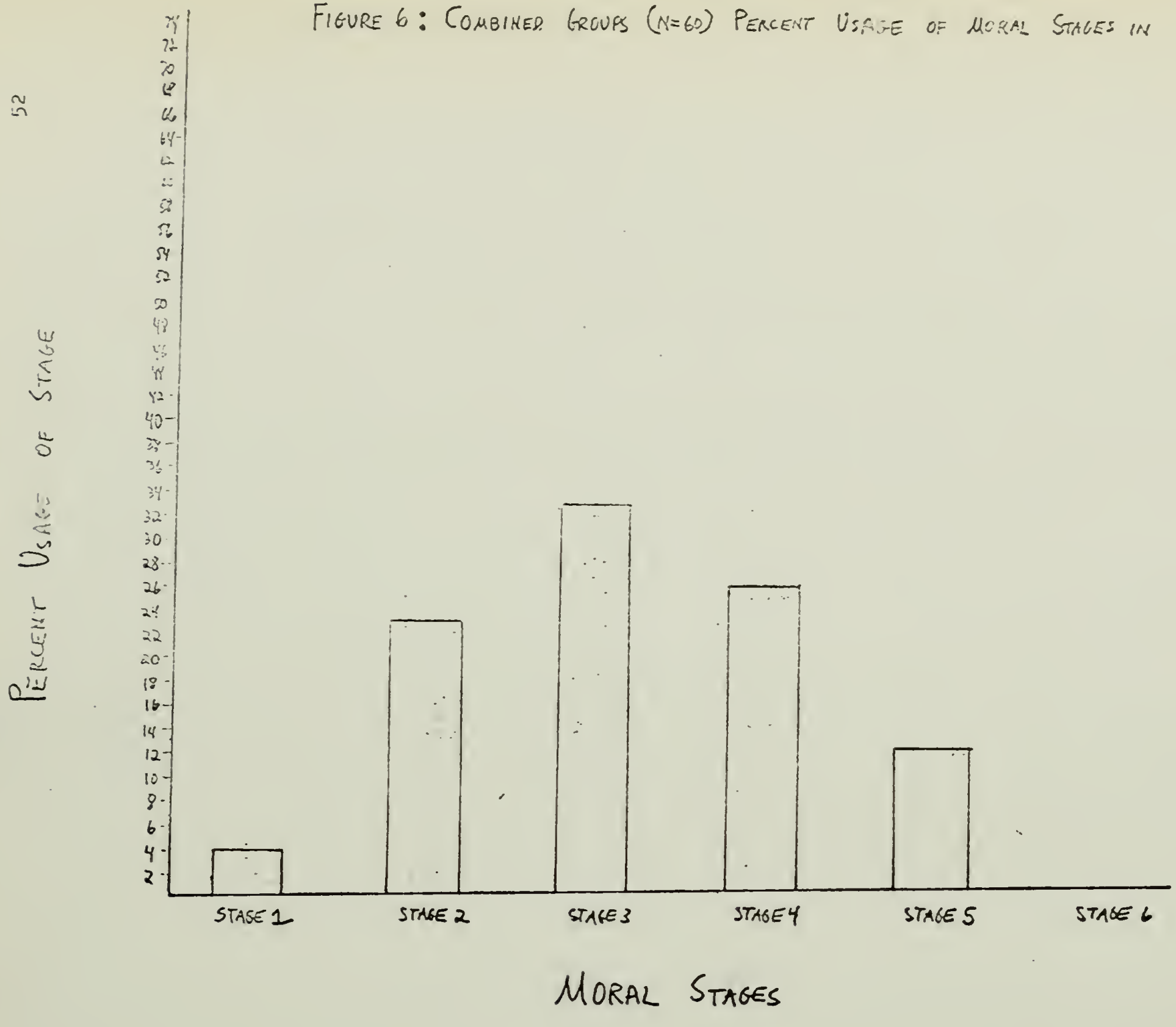


FIGURE 7: COMBINED GROUPS (N=60) PERCENT USAGE OF MORAL STAGES IN SITUATION III.

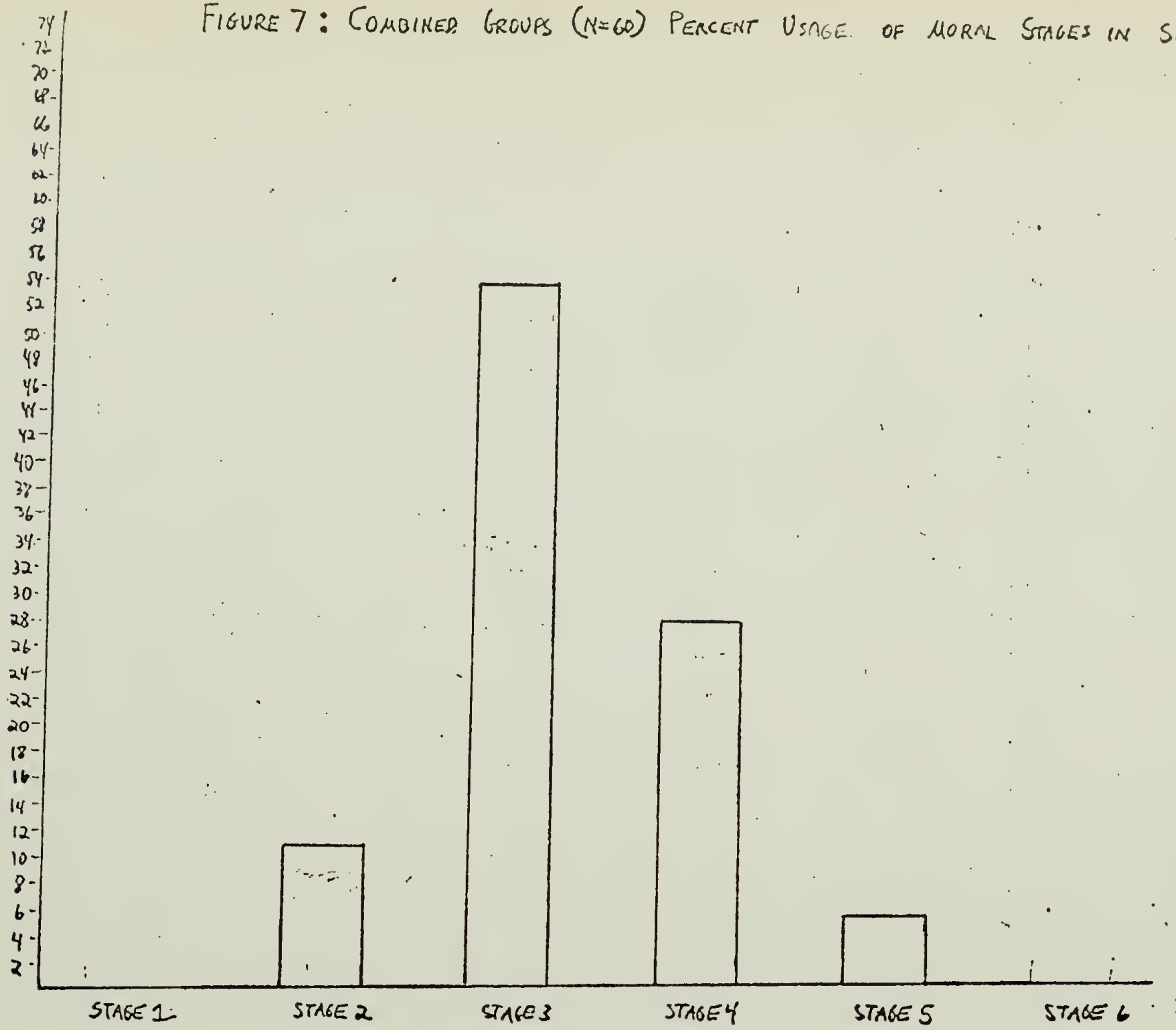


FIGURE 8: COMBINED GROUPS (N=60) PERCENT USAGE OF MORAL STAGES IN SITUATION IV.

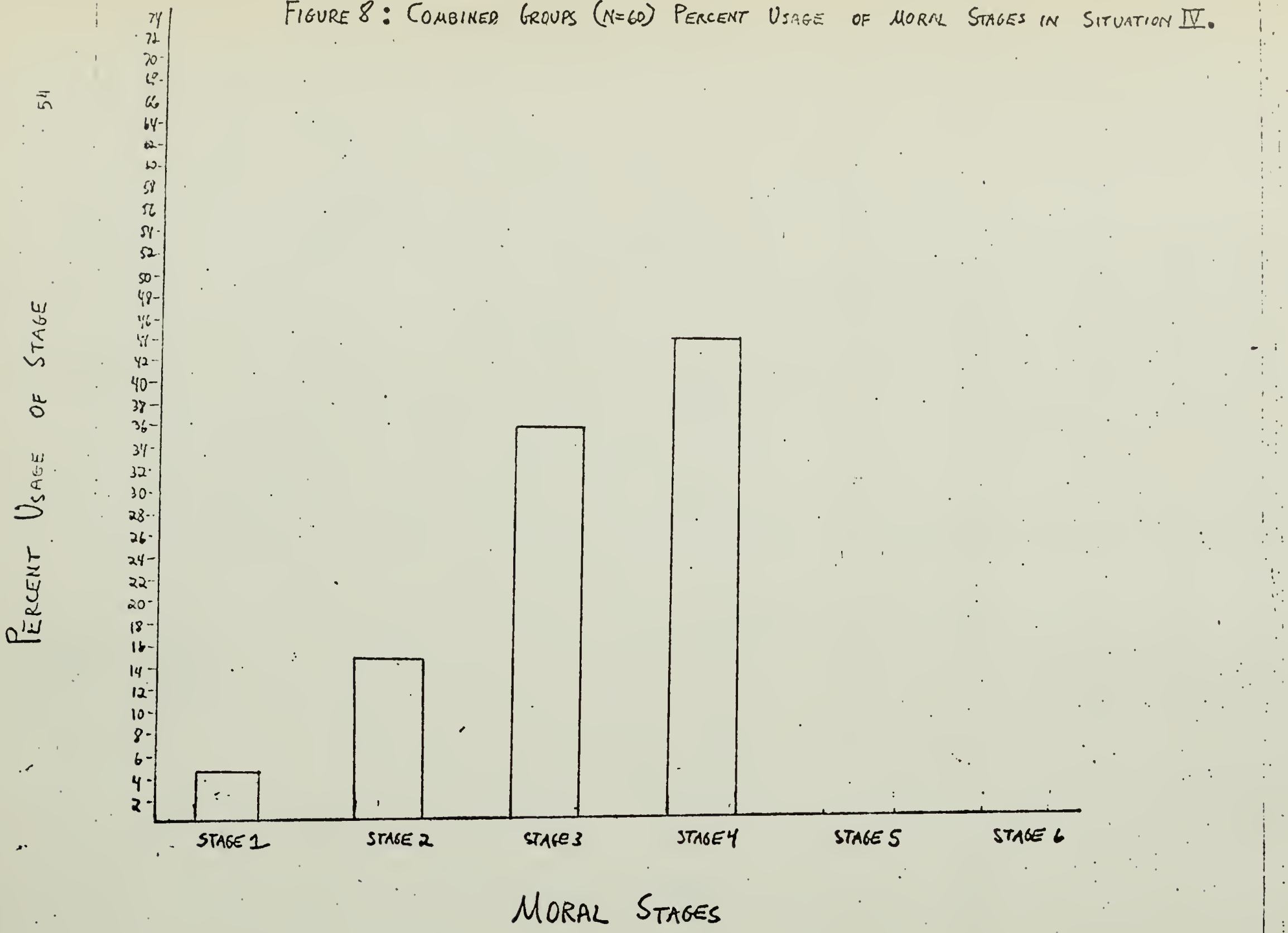
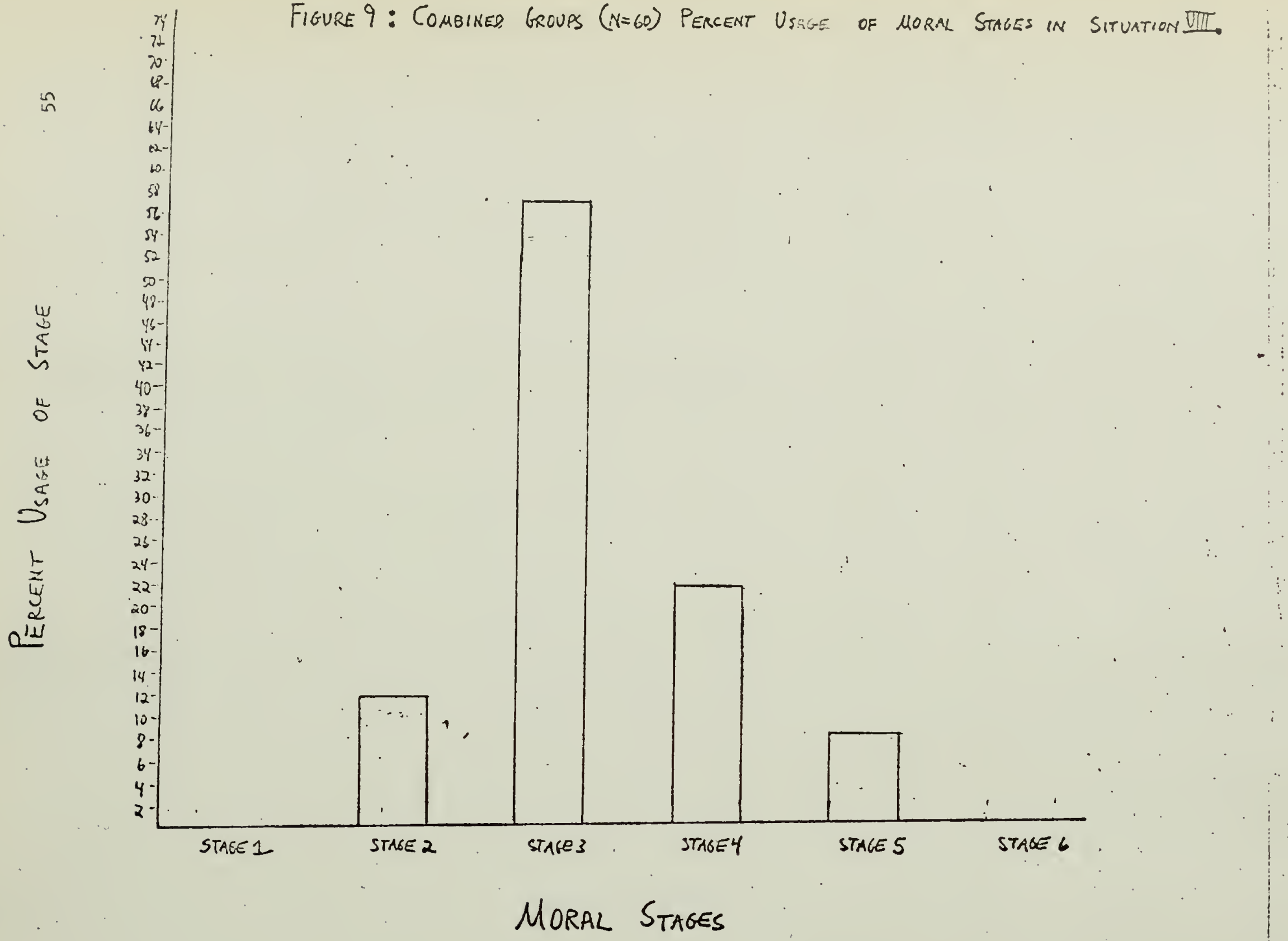


FIGURE 9: COMBINED GROUPS (N=60) PERCENT USAGE OF MORAL STAGES IN SITUATION VIII.



IV. DISCUSSION

A new approach to psychopathology research. In other sections of this thesis an attempt was made to conceptually tie together the areas of morality, interpersonal life, and emotional disorders. One problem the interpersonal-existential view of mental illness has faced in the past has been the challenges from psychologists of different theoretical persuasions that the above-mentioned connections are flimsy, literary, ivory-tower speculations. The work of Kohlberg in creating a system, a measure, and a scale of moral development may help to provide some answer to critics of the humanistic approach to mental illness.

Kohlberg's contention that morality consists of the way the individual structures his relations with others, his emphasis on the necessity of role-taking opportunities for the development of reciprocity and mutuality, can lead to hypotheses about the emotionally disturbed. Combining the new information on moral development with already existing interpersonal theories may make possible a broader picture of the world of the mentally ill. This study represents an exploration of the possible relevance of the Kohlberg measure to emotional disturbance, and some comments relating to the practical aspects of employing the Kohlberg system may be of help to future psychopathology researchers.

First, the interview in which the moral conflict stories

and their probe questions were presented was found to be an excellent format for interacting with both mental patients and normal control subjects. The method is flexible enough to allow for additional probing of any key areas, it can withstand several interruptions in administration to accommodate anxious patients, and, most importantly, it has as its basis the relationship between interviewer and respondent. The Kohlberg interview can be seen as a structured clinical interview, since no test is actually being taken, all the patient's responses are verbal, and a degree of rapport can be established in the situation. The interviewer, in an intuitive sense, learns more about the patient than his Kohlberg stage of moral judgment after spending an hour with him in discussion of the conflict stories. This additionally informative aspect of the interview can be of especial importance in the hospital setting, where knowing the patient should be a goal along with the acquisition of research information.

While the Kohlberg system does make the concept of morality researchable, and does provide a framework in which interpersonal life and mental illness can be included, it does present some practical problems for the researcher. First, scoring is complicated, requiring careful analysis of all the subject's responses. Training by Kohlberg and his assistants at their yearly workshop is a necessity at this point in time. Kohlberg's scoring manual, as of this date,

is still sketchy, and it is liable to leave the scorer basing a number of judgments on his intuitive feel for the stage system. Even with a detailed scoring manual, it would still be crucial to learn and understand Kohlberg's system before attempting to score protocols. This is not a test with a key for scoring, and theoretical knowledge is indispensable to the competent scorer. So the demands on the future scorer for training, theoretical understanding, and time for scoring itself, are large for the Kohlberg measure. The benefits, however, include the use of a measure that allows the subject to define his own socio-moral world, a measure supported by substantial research and validation. It is to be hoped that researchers in the fields of interpersonal relations and psychopathology will attempt to employ this measure, and keep pace with the new findings of Kohlberg and others in the presently fast-evolving field of moral development research.

Schizophrenic, neurotic, and normal moral judgment. In this study, the Kohlberg system was employed in an attempt to understand the nature of the socio-moral world of the schizophrenic, neurotic, and "normal" individual. The finding of the greatest general significance in this study is that the socio-moral world of the schizophrenic is different from that of the "normal" individual. It is a more primitive, withdrawn, non-mutual mode of experiencing the world, a more extreme instance of a failure of relation than is found in

a "normal" individual's moral judgments. Most striking is the schizophrenic group's reliance on Stage 2 Instrumental Relativist thinking, which comprised approximately 27% of their overall stage usage. A more vivid and complete sketch of the premoral approach of schizophrenics can possibly be obtained by a further description of the quality of Stage 2 thinking. Several theoretical formulations of the schizophrenic experience may also be helpful at this point.

Of particular importance from the perspective of the present study is the work of Macnab (1965), a clinician-theologian who takes an existential look at the nature of schizophrenia. Macnab stresses the significance of Buber's insights in conceptualizing the interpersonal experience of the schizophrenic:

> In the person suffering from this condition (schizophrenia) we may see varying degrees of negation and distortion of all that is implied in Buber's community, dialogue, and I-Thou. Relation is diminished and reciprocity virtually lost. The It tends to predominate in its talking-about, manipulating, observing, and experiencing the other without entering a relation. Meaning and significance of life either are absent or undergo distortions involving the categories of time, space, causality, and substance. [p. 151]

A look at the characteristic judgments of the Stage 2 moral thinker clearly indicates an I-It type of existence. The capacity for reciprocity exists only in an exchange or revenge sense, as there is little ability ot understand the other's feelings in a situation. All actions revolve around the self, and others are used for self-gratification or

personal survival needs. Indeed, others are experienced as "things" or "objects" in a solipsistically defined world. For the schizophrenic, "turning toward the world" and "entering into relation" with others are extremely problematic areas, with the individual often resorting to taking the whole world inside himself to avoid this tension and the call to responsibility. This is expressed quite well in Stage 2 moral thinking, where the self is the sole locus of importance in the world. All exchange is literal in nature, with a definite payoff in store for the self. In this stage, other people exist, but they are not perceived as feeling, needing, or loving persons. Thus, a pure Stage 2 thinker might (in response to a Kohlberg moral dilemma) say he would steal a drug to save his wife's life, but only because she was a good cook and he liked to eat. Clearly, in Buber's terms, no Thou is present, the Stage 2 thinker is "intimate" or "real" with no one. The world outside the self becomes increasingly objectified until the only source of life is the self, and the internal world becomes raised to cosmic levels.

The crisis experienced by the schizophrenic can be viewed, then, as a moral-interpersonal crisis, a lack of relational capacity and mutuality. Mowrer (1961) believes "...that in neurosis and psychosis the afflicted individual is in a moral and spiritual crisis...[p. 79]," and Boisen (1936) adds that "...religious concern and religious consciousness tend to appear whenever men are facing the issues

of life and are seeking to become better. Whenever this involves severe conflict pathological features are likely also to appear [p. 82]." While similar moral crises occur in some degree at some point in the lives of most individuals, for neurotics, and particularly for psychotics, a smooth, "natural" adjustment or resolution does not occur. The crisis, at this stage, serves not to facilitate development, but to color, characterize, and control the whole of life itself. In this broader context, Kohlberg (1969a) comments that "the crisis and turning points of adult identity are often moral. From St. Paul to Tolstoy, the classic autobiographies tell us the dramas of maturity are the transformations of the moral ideologies of men [p. 95]." Mental illness may be such a crisis, and can be such a turning point, but too often it becomes a way of life, leaving the individual to create an existence out of his failure to make a choice, his failure to develop. The work of Boisen (1936) on successful and unsuccessful (or pathological) religious conversions, and Laing's (1967) view of the "voyage" of the mad are relevant here. As Laing (1967) says, "Madness need not be all breakdown. It may also be breakthrough. It is potentially liberation and renewal as well as enslavement and existential death [pp. 133-134]." In moral terms, crises can cause us to grow, to mature in our relations with others, or they can cause us to run from others, from responsibility and from adulthood, and leave us concerned only with our-

selves. The heavily premoral Stage 2 world of the schizophrenic described in this study can be understood as representing the less adaptive reaction to the crisis. The unhappiness associated with this state, the experiencing of the failure of relation, the yearning for the Thou, cannot be avoided, it would seem, unless a withdrawal from the world is made complete. In these instances, it is just this "human" quality of the regressed mental patient that observers note as being glaringly absent. In most less severe cases, the crisis rages on, for it still has not been confronted directly and worked through.

For the neurotic individual, moral judgment was found to be not significantly different from the levels of judgment of either schizophrenic or normal persons. The neurotics' moral scores are slightly higher than the schizophrenics', and are a good deal lower than the normal subjects'. The ten neurotic individuals in the present study appear to represent a middle ground of moral development between the two extremes of psychotic and normal. Some basic differences between all three of the above groups are revealed, however, in a consideration of their differential usage of the various moral stages.

The schizophrenic patient employs the greatest average percentage of Stage 2 thinking (27%), followed by the neurotic patient (15%) and the normal patient (8%). The neurotic patient uses the highest percentage of Stage 3 thinking (53%),

followed by the normal group (45%), and the schizophrenic group (40%). And in Stage 4 usage, the normal group leads with an average percentage of 34%, followed by the schizophrenic group (30%), and the neurotic group (20%). Stage 5 thinking was sparingly employed, with normal and neurotic patients using approximately the same average percentage (10% and 11%, respectively), and schizophrenics barely indicating any use (1%).

These percentages of stage usage provide some additional information to be used along with the contrasting of mean scores of the three groups in the study. The neurotic patient's moral judgment consists mainly of conventional (and a small percentage of postconventional) modes of thought, particularly the Stage 3 conception of the "good boy" role, of maintaining societal expectations. While the schizophrenic patient also uses a good deal of Stage 3 thinking, he also relies on an extremely high percentage of Stage 2 usage and is virtually devoid of Stage 5 thinking.

The similarity between the mean scores of schizophrenic and neurotic patients seems to be due in part to the schizophrenic's high amount of Stage 4 usage, second only to normal group usage. It is Kohlberg's (1969a) contention that normal adult moral development consists of the

> dropping out of childish modes of thought rather than the formation of new and higher modes of thought...the major change in moral though past high school is a significant increase or stabilization of conventional morality of a Stage 4 variety,

> at the expense of preconventional stages of thought...Much adult moral stabilization seems to be not development but socialization or internalization of the conventional code. [pp. 106-108]

This is just what appears to be lacking in the schizophrenic patient, despite his high Stage 4 usage. The childish, premoral Stage 2 mode of thinking is still important to this individual, and while conventional stages of judgment are employed, there is no stabilization or consistency around one stage, or even one level, of moral judgment. The range of high-percentage stage usage for neurotic patients centers around Stage 3 thinking, with relatively small amounts of Stage 2 and Stage 4 thought being employed. For normal patients, Stage 3 is again the predominant stage, there is almost no use made of Stage 2, and Stage 4 is drawing closer to becoming the major stage. For the schizophrenic patient, however, the range of stages includes Stage 2, Stage 3, and Stage 4, with Stage 2 and Stage 4 almost identical in percentage of use.

The normal group, then, appears to represent the development of moral judgment along the lines described above by Kohlberg. Normal individuals show a stable usage of conventional judgments, with Stage 4 drawing close to the simpler Stage 3 as the modal stage of use. The neurotic individual centers his judgments almost exclusively in Stage 3 conceptions, showing few signs of progression to the more highly developed Stage 4 concepts. The neurotics' judgments are largely conventional, but somewhat naive, based less on

societal norms, rules, or standards, than on hoping to fill a natural or "good" role in society.

Conventional moral judgments imply the ability to live in the real world with others, the ability to take the role of another. It is this capacity, present in normal and neurotic individuals, that is diluted in schizophrenic moral judgment. By using a high percentage of Stage 2 responses, the schizophrenic is autistically coloring his moral judgments. He may live and interact with other people, but his unstable basis of moral judgment provides for an easy regression to the physical, literal exchange philosophy of Stage 2. There is a quality of blind, frightened self-preservation in Stage 2 thinking, a "looking out for Number One." For the schizophrenic, in times of stress of conflict, conventional modes of judgment may be replaced by the simpler, less demanding, more purely defensive moral stance of the Stage 2 thinker. The high percentage of Stage 4 among schizophrenic persons indicates their ability to employ conventional moral judgment, but there is little stabilization at one stage or one level, little natural progression from stage to stage. The schizophrenic can be seen as experimenting with a variety of ways of living with others. Consistency and stability are what is lacking; the faith in the social world necessary for a relinquishing of premoral self-oriented concepts has not yet been established. The schizophrenic patients interviewed in this study were those patients who were able to relate in

some degree to another person, who were in fairly good contact with the real world. The more regressed, withdrawn, and acutely disturbed schizophrenic, it is hypothesized, would have presented an even stronger premoral aspect.

The predicament of mental patients, particularly schizophrenics, in regard to moral development becomes clearer if we note, once again, the growth-medium of morality:

> If moral development is fundamentally a process of the restructuring of modes of role-taking, then the fundamental social inputs stimulating moral development may be termed 'role-taking opportunities' ....The more the social stimulation, the faster the rate of moral development. [Kohlberg, 1969, p. 399, p. 402]

Social stimulation, "role-taking opportunities," are what the schizophrenic lacks in his largely isolated and private world. A point that is discussed in more detail below is that many forms of psychotherapy have as their goal greater social, or interpersonal, contact for the patient, and this stress on living with others may be aiding the development of moral judgment. The therapist himself provides role-taking opportunities for the patient, and he may try to make these mutual experiences more possible for the patient in the world outside the therapist's office. This increased social stimulation may be responsible for a consequent increase in level of moral judgment on the part of the patient.

The relation of other variables to moral judgment. In regard to role-taking, marriage would appear to be an

extremely powerful social experience that could provide an opportunity to aid moral development. The closeness and mutuality that are possible in marriage, the opportunities for confirmation of each partner by the other, make it likely that this relationship would be a reciprocal one, each partner experiencing the effect of his actions on the other. The results of the present study do indicate that marriage is strongly related to the stage of moral judgment reached. Married people, mental and medical patients alike, tend to show a higher level of moral cognition than do their single counterparts. The effect of pathology, however, is equally significant, and so while married mental patients might possess a higher level of judgment than do single mental patients, both these groups are at a lower level than either single or married normal individuals. It is interesting that, in the hospital studied, the number of married mental patients is far smaller than the number of married medical patients. It may be that many mental patients have not been able to meet the interpersonal demands inherent in marriage. They remain single, thereby missing another opportunity for moral growth, and increasing the vicious circle of isolation leading relentlessly to ever-greater isolation.

In discussing interpersonal life and morality, the area of religion easily comes to mind. Both Mowrer (1961) and London (1964) point to religion as once having offered

people a sense of community, but both these psychologists now feel that religions have failed in this endeavor. London (1964) goes so far as to say that psychology, or science, will take the place of religion, noting "the clergy have tended to abdicate their claim to moral competence in favor of psychology, and the congregations have, by and large, resigned from their clergy [p. 172]." The current popular obsession with encounter and sensitivity groups, and the various youth movements (communes, Woodstock) seem to indicate that people are feeling a lack of and a desire for community. Many people do not feel that the conventional religions presently offer any relief from alienation or any hope for the future. Indeed, Mowrer's (1968) group therapy is a secular substitute for the old-time religious communities, where secrets and problems were shared not just with a confessor, but with the whole congregation. As a result, the individual felt loved and respected by the group. Perhaps Buber (1958) makes this substitution of a psychology of interpersonal life for religious doctrine more understandable in his discussion of the Eternal Thou. Every Thou in the real world is destined to become an It at some point in time, but God is the Thou who never becomes objectified, He is the Eternal Thou. He can only be met through the real I-Thou experiences of this world, each relation with a real Thou offering us a glimpse of the Eternal Thou. For Buber, then, the world becomes the temple, and

prayer, doctrine, and formal worship are only distractions from the task of living with others. This would seem to be a suitable basis for much of the current emphasis in psychotherapy on interpersonal relations (e.g., Mowrer, Laing, Boss, Trüb).

All this is in preface to the expectation that formal religious affiliation would not seem to play that important a role in determining levels of moral judgment. In the present study, that proved to be the case. Whether this is because the religions themselves are defunct, or because the members are insincere and do not truly live up to the religious precepts, is an unanswered question. No measure was used to judge the seriousness of commitment to the religion, or the nature of that commitment. The only criterion for selecting the religious groups in this study was the patient's statement of affiliation. Most importantly, no control groups consisting of either atheists or individuals with personal (nontraditional) religious beliefs were employed. All that can be said at this point is that the Protestant, Catholic, and Jewish groups did not differ significantly in moral judgment. The basis for the significant difference between mental and medical Jewish patients (medical Jewish patients being higher in moral judgment) is unclear at this point due to small sample size and poor criteria of religiosity.

The variable of age considered in this study also did

not seem to have any relation to moral judgments. Since all subjects were over twenty years of age, and most were over thirty years old, this is not too surprising. Differences in moral judgment in adulthood, as we have seen, center around stabilization of judgments, which depends not on the age of the adult, but on the quality and nature of his interpersonal and societal experiences.

A final point to note in reference to the results of the present study is the finding that the number of hospitalizations for a patient was unrelated to his level of moral judgment. It should be made clear that the hospital used is a short-term mental hospital, and so only five out of thirty mental patients had four or more hospitalizations. In a longer-term hospital, the trend may have been different, and certainly the sample size of the many-hospitalization group would have been more substantial. In multiple, or lengthy, hospitalizations, due to a prolonged experience of I-It dealings with others, there could be a severe atrophying of moral judgment. These long-term patients might fit in well with the institution's workings and routines, but they can be seen as cogs in the machine, objects, "burned-out cases," and their moral judgments should be similarly regressive.

Moral development and psychotherapy. The logical question that should follow after a description of schizophrenic and neurotic stages of moral development is "What use can you make of this information?" The question that

will be dealt with here is the more specific, "What are the implications of this and other moral development research for psychotherapy?"

At one level, the allowance for, and general encouragement of, relatedness and mutuality in therapy is of some benefit to the patient in a moral sense. It offers him a chance to be real with one other individual, to be exposed to another's moral judgments and principles. This raises the issue of the therapist as a "values change agent," bringing the patient more into contact with a conventional way of life, a way approved by society. London (1964) claims that this is an inevitable aspect of the therapeutic arrangement, that "the manipulative character of psychotherapy can no longer be in serious doubt either logically or empirically...[p. 157]." He finds no ethical conflict in this fact, believing

> The therapist's scientific job, from any viewpoint, begins with his gaining information that he can then use to manipulate, direct, or channel behavior, whether the behavior in question is the discovery of hidden motives, a change in habits, or a realignment with society. [p. 158]

Rosenthal (1955)found that neurotic patients who improved in individual therapy "tended to revise certain of their moral values in the direction of their therapists', while the moral values of the patients who were unimproved tended to become less like their therapists' [p. 435]." Rosenthal's study, however, dealt with moral attitudes, not cognitively

defined modes of judgment. These moral opinions seemed largely based on socio-economic class standards as to what is right or wrong, good or bad. The extremely small sample size of the study (12) makes its results merely suggestive.

One difference between Kohlberg's stages of development and the moral attitudes and standards mentioned above, is that the Kohlberg stages are content-free. That is, a person could respond in two apparently opposite ways to a conflict story and still manifest the same stage thinking. Kohlberg deals with the structure of moral thought, not the content of responses or surface attitudes. To call the therapist a moral change agent could mean only that he puts pressure on the patient to mouth conventional ethical beliefs. If this is the case, the structure of the patient's thinking, the actual nature of his socio-moral world remains unknown, and the effect the therapist has on the area of moral cognition is unclear. London (1964) calls for the therapist to employ scientific knowledge in his role as change-agent, and it may be possible for Kohlberg's research to be used as a basis for a view of the therapist as "moral development" agent, in a carefully defined sense.

An example of the difficulties a therapist can get into if he deals only with surface attitudes and opinions in his therapy, and if he is unaware of the stage of moral thinking his patient is employing, is given in this statement by Kohlberg (1969):

> The problem posed by stage theory is that the stimulus inputs received by the child are usually either assimilated to his own level or are not perceived as stimuli at all. As an example, a Stage Two delinquent is offered 'role-taking opportunities' by an understanding psychotherapist, but these opportunities are perceived as opportunities to 'con a sucker' and do not stimulate development beyond Stage Two.... [p. 402]

This example points to the value of viewing moral judgment as an important issue in therapy, for whatever the value system or therapeutic goals the clinican might possess, his effectiveness could be improved by a knowledge of what cognitive abilities the patient has in responding to his treatment. This seems especially true for the schizophrenic patient, as he lacks some of the cognitive skills necessary for conventional moral judgment and reciprocal role-taking. The therapist may be able to proceed more efficiently by structuring his treatment to the socio-moral world of the patient.

How can the knowledge of the patient's stage of moral development be used to any benefit by the therapist? First, in a general sense, Kohlberg (1969a) writes "Moral development involves a continual process of matching a moral view to one's experience of life in a social world. Experiences of conflict in this process generate movement from structural stage to structural stage...[p. 118]." In dealing with patients who show a difficulty in moving developmentally from stage to stage, carefully structured discussions of abstract or hypothetical situations may help the patient to deal with

his cognitive conflicts in a more direct and successful fashion. Either a fixation at or regression to a premoral stage, or a confused scattering of judgments across levels can be possibly alleviated by a clear focussing of attention on the moral judgment area. The therapist could discuss moral conflict stories with the patient, and could present various alternative ways of looking at a moral choice situation (not necessarily views which are characteristic of the therapist's own stage of judgment). In an atmosphere of a free exchange of views, the patient can be aided in reorganizing his problematic and unstable moral judgments by exposure to other opinions and resolutions of moral-interpersonal conflicts. A natural development of the patient's mode of moral thinking may result from this educational experience.

Dealing with the technical aspects of moral education, Kohlberg (1969) writes

> The problem of moral change would appear to be one of presenting stimuli which are both sufficiently incongruous as to stimulate conflict in the child's existing stage schemata and sufficiently congruous as to be assimilable with some accommodative effort....With regard to the assimilation of moral judgments made by others, the 'match' notions just presented suggest that there would be maximal assimilation of moral judgments one level above the S's own....Presumably a sense of contradiction and discrepancy at one's own stage is necessary for reorganization at the next stage. [pp. 402-403]

Turiel (1966) tested this hypothesis in a study involving junior high school students. He found that exposure to the

views of the stage just above the subject's own, rather than the stage directly below or two above that of the subject, resulted in the greatest learning of a new mode of thought. The method used was role-playing, where the child was exposed to two contradictory solutions of a moral conflict story, both of which were examples of stage thinking one step above his own (or one below or two above, in the other, non-significant conditions). Turiel notes

> Since subjects were exposed to new modes of thought through arguments justifying both sides of a moral conflict, they did not really receive solutions to the problems. Such a situation, which exposed subjects to cogent reasons justifying two contradictory positions, could have resulted in cognitive conflict arising from an active concern with both sides of the issue. When the arguments were too 'simple,' as in the -1 treatment, the subjects may not have become actively involved. When the arguments were too 'complicated,' as in the +2 treatment, the subject may not have understood them. However, exposure to concepts one stage above, concepts within a subject's grasp, allowed him contact with new contradictory ideas requiring thought. Perhaps coping with concepts that had some meaning to the subjects led to new modes of thinking, or to a greater use of the stage that was one above the initial stage. [p. 617]

How much of what a therapist says to his patient is either rejected as too simple, or not comprehended because it is out of the patient's realm of thinking? It may be possible to employ techniques similar to Turiel's, i.e., role-playing in discussions of the Kohlberg stories, based on a knowledge of the patient's stage of moral judgment, in psychotherapy. The goal would be the moral education of the patient, the development of his capacity for reciprocal role-relationships.

It may be useful to examine the area of moral development and moral change in psychotherapy, with especial regard to those therapies which stress moral issues and concerns.

Dealing with values, giving advice, and assuming a good degree of responsibility for the patient's treatment are not practices typically associated with psychotherapy. An increasing number of therapists, however, are emphasizing the importance of morality and responsibility in working with patients, particularly severely disturbed patients. Glasser's (1967) Reality Therapy aims at helping the patient

> to acknowledge a set of values as early in the therapy as possible. We then discuss his behavior in terms of whether he thinks he is doing right or wrong according to these values. There is usually little difficulty in arriving at his values; the difficulty lies in helping him to live responsibly in accordance with them. [p. 129]

Glasser's contention, stated in different forms by Buber and Kohlberg, is that self-respect and closeness to others are the two basic needs of human beings. Clearly, in Kohlberg's Stage 1 and 2 thinking, a stable self, mutual relationship, and responsible living are impossible. So to implement Glasser's ideas an effort would first have to be made to expose the premoral patient to conventional judgments, to stress responsibility, reciprocity, and a life with others. The method of choosing the stage one above the patient's to be the setting for discussion of conflicting moral choices, and the findings indicating a natural moral

growth capacity in an upward direction, make the Kohlberg moral development approach a logical adjunct to Glasser's Reality Therapy. Glasser's model of emphasizing correct and responsible actions may frequently be meeting the criteria of moral development by presenting one-stage higher concepts to premoral patients.

Mowrer (1961, 1964) has often written that the goal of complete freedom for the patient is an inadequate one for therapy. He comments,

> My own growing conviction and that of others is that we are crushed, not by the tyranny of the culture, but by our own short-sighted attempts to evade the cultural demands and live, as we often say, 'our own life!' [1964, p. 106]

This is an apt description of Stage 1 and 2 thinking and action, an attempt to live apart from others, with the resulting failure and dissatisfaction.

Lederer (1967) also emphasizes the need to build up a "superego" in appropriate cases, and he calls this process "pedagogic" therapy. Although his discussion employs psychoanalytic terms that may obscure the issue, he is also promoting a life with others, a life based in society. The therapist, or pedagogue, actively encourages and educates the patient in the necessary capacities required for interpersonal existence. Lederer (1971) feels this concern with morality is justified, for

> if desertion of morality indeed causes a sense of alienation, and if alienation is the chief psychic ailment of our times, then is it not the duty of the

> alienist, the psychiatrist, to concern himself with morality, or rather, the lack of it, as, at the very least, one of the possible causes of the ailment? [p. 84]

Describing the role of the psychotherapist, Lederer (1971) continues

> Unlike the preacher, we do not advocate any particular code of ethics nor, by and large, are we to prescribe any particular course of action. But we must, I think, insist with our patients that they consider the right and the wrong of their actions carefully in the light of their own standards; that they expose their standards to the buffeting of diverse opinion; and that they try hard to identify and to dispel excuses and rationalizations and to arrive at the essential truth of their position. [p. 85]

The therapy hour can serve as a forum for discussion of values and of moral issues. The Kohlberg system can create some order out of the often confusing realm of morality. It can explain moral judgment in terms of developmental stages, and it allows for a structural understanding of different moral philosophies and the progression from stage to stage. Whereas Lederer discusses morality in general terms, Kohlberg is precise in his distinction between levels of moral judgment, and this can be of great help to the therapist.

Lederer (1967) writes,

> The pedagogue maintains, as pedagogues have throughout history, that life is a game that can be played in many ways. If one wishes to play it well, he must first master it according to the local ground rules [Stage 3 and 4 morality], and the proper use of these rules permits considerable freedom and spontaneity; greater freedom comes from the recognition that the rules are largely

> arbitrary, and can be changed [Stage 5 morality] .... [p. 97]

Although the above discussion provides a surprisingly accurate parallel to Kohlberg's sequence of stages, formal analyses of both premoral and highly principled modes of judgment are absent. In addition, a description of how development of forms of "game-playing" occurs is lacking in Lederer's treatment of morality. The Kohlberg stage schema seems to provide a cogent example of how a teaching-approach or "pedagogic" therapy can actually be implemented. Relying on his knowledge of the patient's level of moral judgment, the therapist, or pedagogue, can employ the research findings on moral change to help the patient move from more primitive to more societal philosophies of existence. Once at a conventional level, more subtle problems in living with others can be dealt with by a variety of therapeutic techniques. It would seem necessary, however, for the patient to be initially helped, in an active fashion, to develop beyond his premoral, asocial philosophy of life to a more conventional socio-moral outlook. He needs to learn how to operate within the system, at this stage in his development. He needs to learn and to feel comfortable with the "ground rules" of life in society.

This approach, using the Kohlberg constructs and techniques to help the patient move along the sequence of stages, is not aimed at fostering a blind conformity. As Glasser,

Mowrer, Lederer, and others have maintained, an active role for the therapist does not automatically imply a police state or a therapy of conformity. More specifically, in the Kohlberg system the most limited, rigid, and restricted lives imaginable are those lived by Stage 1 and 2 moral thinkers. Their physically oriented world is frequently threatened by life situations, and their hermetic existences make them susceptible to the slightest pressures. In contrast, the postconventional Stage 5 and 6 thinkers are free, flexible, able to balance the demands of self and society, and are even capable of stepping outside the society to fight for personal principles of justice and reciprocity. Sophisticated moral judgment leads not to a destruction of the will, but to an emancipation of the will, the creation of a will which rises above the self to include the world in its concerns.

The therapist's values will become apparent in a morality-based therapy, but the goal is never the patient's acceptance of the therapist's particular beliefs. The therapist may model the various Kohlberg stage responses to moral dilemmas in an attempt to help the patient develop new capacities in resolving cognitive conflicts. Kohlberg writes in terms of the existence of a natural trend to use more sophisticated or complex stages of judgment, a natural growth capacity of the moral judgment area. The moral-development approach is not authoritarian, but educational in nature. The goal is

to expose the patient to alternative modes of thought, not to espouse any one moral philosophy or ethic. As Parlour, Cole, and VanVorst (1967) write, "...an active, directive stance by the psychotherapist need not inhibit personal development or the development of mature independence and responsibility [pp. 138-139]."

Indeed, a Kohlberg-oriented therapy would help to avoid some of the limitations often found in morally based treatment. Most importantly, the identification with and stressing of a single moral concept or belief (e.g., Mowrer's emphasis on confession, Glasser's focussing on responsibility) could be avoided by a therapist who worked within the format of Kohlberg's stage theory. The distinction between a teacher and a preacher is crucial here, and the aim of the Kohlberg-oriented therapist would be to educate, not to convert the patient to a particular philosophy of life. The Kohlberg system is helpful in that it provides the therapist with knowledge of a whole range of valid moral philosophies.

It is surely possible for the patient to rise to a level above the therapist's, although his development into the principled stages might well occur after the termination of individual therapy. A solid conventional moral philosophy, with an emphasis on responsibility and mutuality, may leave the patient capable of maturing without the continued process of individual assistance. The hypothesized need we all have for community, the need to avoid lives of privacy,

secrecy, and shame may perhaps be best alleviated by group experiences, actual experiences of community.

Group psychotherapy, then, would appear to be an initial extension of the concern with moral judgment and interpersonal life. Macnab (1965) maintains that

> If Buber's thought is followed and accepted in psychotherapy, the medium of the group assumes a fundamental role and significance, for it is in such a setting that the sick man might realize himself and rediscover the meaning of his life in the world. [p. 151]

The group-process has a more explicitly "moral" nature in Mowrer's (1968) Integrity Therapy group, where the emphasis is on confession of guilt and positive actions toward others in the social world. Mowrer is concerned with and bothered by the exclusively personal nature of most therapies, and he sees the need to turn the patient toward the world, to break up the secret and private milieu of therapy. He writes,

> What a terrible waste of time it is seeing a 'counselor' who never counsels us to do anything but continue talking to him! And group therapy, while an improvement over most individual counseling, can also fall short of full effectiveness if it becomes ingrown and does not encourage its members to reach out to, and often incorporate into the group, 'significant others.' [p. 149]

The Kohlberg moral conflict stories can perhaps provide a means of turning the group to broader, societal concerns. By carefully selecting patients to insure a range of different moral stages in the group, and by using a therapist who understands the stage schema, the group could serve as a setting for a discussion in which individuals would be

exposed to a variety of moral views. This would perhaps result in patients' development from stage to stage. While the group could deal with other, more traditional, issues, this method of concentrating on moral conflict issues might be especially helpful to the schizophrenic patient. Mowrer's groups, stressing confession and responsibility, require a good deal of social skills and self-awareness, and there would seem to be no place for the severely disturbed schizophrenic within them. But if in addition to an Integrity Therapy or other group therapy approach, the group dealt directly with moral conflicts, the schizophrenics could be exposed to higher stage thinking, and might better be able to participate adequately by giving their own opinions. The more they assimilated conventional modes of moral judgment, the more the group as a whole could operate in a less structured fashion. The Kohlberg stories might be used, then, as an adjunct to other therapies, individual and group. They may be of particular importance in their potential for bringing the patient with the most alienated socio-moral world, the schizophrenic, into closer contact with others and with the community as a whole.

Conclusions and implications. Man faces many paradoxes in life, but one of the most problematic of these is his simultaneous need for both individuality and relationship. One's actions, it is hypothesized, have to satisfy both needs. A balance must be established between the self and others.

This is the arena of morality, which deals with the nature of the resolution of this conflict between man and society. One extreme position stresses the individual, the self, but the self seems to be unable to survive in social isolation. On the other hand, to live purely for others is another form of "losing" ourselves.

The Kohlberg framework describes the different forms this attempt at "balance" or "stability," or, if you will, "mental health," can take. For the psychotic, the non-self of alienation is raised to unnatural, eerie heights, and the Thou, or relation, is longed for in a private torment. Understanding the psychotic's level of moral judgment makes more vivid the failures of their interpersonal life, their unsatisfied need for connection and communion with others. Higher moral stages, found in more "normal" individuals, show an acknowledgment of the society, and indicate some success in being a separate person while maintaining a relationship to others. Identity is established while relation is developed.

The moral-interpersonal realm deals with the person's way of coping with this ontological paradox, and can add further understanding to the concepts of what is "sick" and what is "normal" behavior. This additional knowledge of the person's cognitive mode of moral judgment could be especially helpful to a therapist who is actively concerned with these same issues of self-in-society. Man can be seen

walking a tightrope, trying to keep his balance, to be an individual, yet to live in relation with others. When he slips, when he becomes "unbalanced," he falls into the safety net of the mental health professions. It is our responsibility to understand his problems and his failures, and this implies understanding the way he lives as an individual with other people. The more knowledge we have about moral judgment and interpersonal life, the more help we can be to ouselves and to others. The more we understand the various ways of living-in and out-of-community, the better our "net" will be for catching the "fallen." For to slip through the net means to leave this world, and drift in a moral-interpersonal void. Our goal should be to send the person back into the social world, back into the world of the I and the Thou, more capable of fulfilling his dual and inseparable needs for identity and relationship.

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APPENDIX A

Kohlberg Moral Judgment Interview

Instructions for Decision Stories and Questions

I will read some stories to you, and after each story I shall ask you some questions about the story. There are no right or wrong answers to these questions, different people have different opinions. I just want you to give your own ideas and opinions. This is not a test and no one in this hospital will see any of your answers.

SITUATION I. Joe is a 14-year-old boy who wanted to go to camp very much. His father promised him he could go if he saved up the money for it himself. So Joe worked hard at his paper route and saved up the $40 it cost to go to camp and a little more besides. But just before camp was going to start, his father changed his mind. Som father was short of the money it would cost. The father told Joe to give him the money he had saved from the paper route. Joe didn't want to give up going to camp, so he thought of refusing to give his father the money.

I. O. Should Joe refuse to give his father the money? Why?

2. Does his father have the right to tell Joe to give him the money?

1. Does giving the money have anything to do with being a good son?

6. Which is worse, a father breaking a promise to his son or a son breaking a promise to his father?

6a. Why should a promise be kept?

SITUATION III. In Europe, a woman was near death from a special kind of cancer. There was one drug that the doctors thought might save her. It was a form of radium that a druggist in the same town had recently discovered. The drug was expensive to make, but the druggist was charging ten times what the drug cost him to make. He paid $200 for the radium and charged $2,000 for a small dose of the drug. The sick woman's husband, Heinz, went to everyone he knew to borrow the money, but he could only get together about $1,000, which is half of what it cost. He told the druggist that his wife was dying, and asked him to sell it cheaper or let him pay later. But the druggist said, "No, I discovered the drug and I'm going to make money from it." So Heinz got desperate and broke into the man's store to steal the drug for his wife.

III. 20. Should Heinz have done that? Was it actually wrong or right? Why?

23. Is it a husband's duty to steal the drug for his wife if he can can get it no other way? Would a good husband do it?

25. Did the druggist have the right to charge that much when there was no law actually setting a limit to the price? Why?

<u>The next two questions apply only if subject thinks Heinz should steal the drug:</u>

23a. If the husband does not feel very close or affectionate to his wife, should he still steal the drug?

24. Suppose it wasn't Heinz's wife who was dying of cancer, but it was Heinz's best friend. His friend didn't have any money and there was no one in his family willing to steal the drug. Should Heinz steal the drug for his friend in that case? Why?

The next two questions apply if subject thinks Heinz should not steal the drug:

Would you steal the drug to save your wife's life?

If you were dying of cancer but were strong enough, would you steal the drug to save your own life?

Everyone

Heinz broke in the store and stole the drug and gave it to his wife. He was caught and brought before the judge. Should the judge send Heinz to jail for stealing, or should he let him go free? Why?

SITUATION IV. The drug didn't work, and there was no other treatment known to medicine which could save Heinz's wife, so the doctor knew that she had only about six months to live. She was in terrible pain, but she was so weak that a good dose of pain-killer like ether or morphine would make her die sooner. She was delirious and almost crazy with pain, and in her calm periods, she would ask the doctor to give her enough ether to kill her. She said she couldn't stand the pain and that she was going to die in a few months anyway.

IV. 40. Should the doctor do what she asks and give her the drug that will make her die? Why?

When a pet animal is badly wounded and will die, it is killed to put it out of its pain. Does the same thing apply here? Why?

<u>The following questions apply only if subject thinks the doctor should not give her the drug:</u>

41. Would you blame the doctor for giving her the drug?

42. What would have been best for the woman herself: to have lived for six months more in great pain or to have died sooner? Why?

IV. 47. The doctor finally decided to kill the woman to put her out of her pain, so he did it without consulting the law. The police found out and the doctor was brought up on a charge of murder. The jury decided he had done it, so they found him guilty of murder even though they knew the woman had asked him. What punishment should the judge give the doctor: Why?

48. Would it be right or wrong to give the doctor the death sentence?

49. Do you believe that the death sentence should be given in some cases? Why?

SITUATION VIII. While all this was happening, Heinz was in jail for breaking in and trying to steal the medicine. He had been sentenced for ten years. But after a couple of years, he escaped from the prison and went to live in another part of the country under a new name. He saved money and slowly built up a big factory. He gave his workers the highest wages and used most of his profits to build a hospital for work in curing cancer. Twenty years had passed when a tailor recognized the factory owner as being Heinz, the escaped convict whom the police had been looking for back in his home town.

VIII. 80. Should the tailor report Heinz to the police? Would it be right or wrong to keep it quiet? Why?

81. Is it a citizen's duty to report Heinz? Would a good citizen?

84. If Heinz was a good friend of the tailor, would that make a difference? Why?

82. Should Heinz be sent back to jail by the judge? Why?